HEALTH SERVICES AND DEVELOPMENT AGENCY MEETING
OCTOBER 22, 2014
APPLICATION SUMMARY

NAME OF PROJECT:	TriStar Centennial Medical Center
PROJECT NUMBER:	CN1407-032
ADDRESS:	2300 Patterson Street Nashville (Davidson County), TN 37203
LEGAL OWNER:	HCA Health Services of Tennessee, Inc. 2300 Patterson Street Nashville (Davidson County), TN 37203
OPERATING ENTITY:	NA
CONTACT PERSON:	John Wellborn (615) 665-2022
DATE FILED:	July 15, 2015
PROJECT COST:	$96,192,007
FINANCING:	Cash Reserves of the parent corporation, HCA Holdings, Inc.
REASON FOR FILING:	Hospital Construction in Excess of $5 Million, Addition of 29 acute medical/surgical beds

DESCRIPTION:

Centennial Medical Center (CMC), a 657 licensed bed hospital located in Nashville (Davidson County), Tennessee is seeking approval to renovate its main emergency department (ED), develop a Joint Replacement Center of Excellence, and to increase the hospital's licensed bed complement. The project includes approximately 89,318 square feet of renovation, 84,123 square feet of new construction, and the addition of 29 licensed beds.

The project does not involve the initiation of new health care services or acquisition of major medical equipment. The hospital's acute care complement

will increase from 657 to 686 licensed beds. The estimated project cost is $96,192,007. The entire project is expected to be completed by December 1, 2015.

CRITERIA AND STANDARDS REVIEW

CONSTRUCTION, RENOVATION, EXPANSION, AND REPLACEMENT OF HEALTH CARE INSTITUTIONS

3. **For renovation or expansions of an existing licensed health care institution:**

   a. **The applicant should demonstrate that there is an acceptable existing demand for the proposed project.**

   The project will allow for a more functional work flow in the ED with more specialized treatment rooms, improved accessibility for ambulances, privacy for family consultations, treatment rooms with more privacy, and other improvements.

   The projected arrival of the practice, Southern Joint Replacement Institute (SJRI), in November 2014 to CMC's Physician's Park Medical Office will more than double the caseloads of the applicant's Joint Replacement Program from 1,196 joint replacement cases in 2014 to 2,744 cases in 2015.

   The applicant projects that medical/surgical occupancy (excluding observation days) will increase from 70.6% in 2013 to 82.4% in 2017. Including observation days the applicant expects medical/surgical occupancy to increase from 82.8% in 2013 to 96.5% in 2017.

   It appears that the application will meet this criterion.

   b. **The applicant should demonstrate that the existing physical plant's condition warrants major renovation or expansion.**

   This is not a renovation project to remedy the existing plant's condition. This project is to provide new space for new surgical environments for joint replacement patients and renovated space to improve the emergency department.

   It appears that the application meets this criterion.

SERVICE SPECIFIC CRITERIA AND STANDARD REVIEW

ACUTE CARE BED NEED SERVICES

1. The following methodology should be used and the need for hospital beds should be projected four years into the future from the current year:

   Using the latest utilization and patient origin data from the Joint Annual Report of Hospitals and the most current population projection series from the Department of Health, perform the following:

   Step 1

   Determine the current Average Daily Census (ADC) in each county.

   $$ADC = \frac{\text{Patient Days}}{365 \text{ (366 in leap year)}}$$

   Step 2

   To determine the service area population (SAP) in both the current and projected year:

   a. Begin with a list of all the hospital discharges in the state, separated by county, and showing the discharges both by the county where the patient actually lives (resident discharges), and the county in which the patient received medical treatment.

   b. For the county in which the hospital is (or would be) located (service county), determine which other counties have patients who are treated in your county (resident counties). Treat all of the discharges from another state as if that whole state were a single resident county. The total discharges of residents from another state should be calculated from state population estimates and the latest National Center for Health Statistics southeastern discharge rates.

c. For each resident county, determine what percent of their total resident discharges are discharged from a hospital in your service county (if less than one percent, disregard).

d. For each resident county, apply the percentage determined above to the county's population (both projected and current). Add together the resulting numbers for all the resident counties and add that sum to the projected and current population of your service county. This will give you the service area population (SAP).

Step 3

Determine projected Average Daily Census as:

$$\text{Projected ADC} = \text{Current ADC} \frac{\text{Projected SAP}}{\text{Current SAP}}$$

Step 4

Calculate Projected Bed Need for each county as:

Projected Need = Projected ADC + 2.33 x □Projected ADC

However, if projected occupancy:

$$\text{Projected Occupancy:} \quad \frac{\text{Projected ADC}}{\text{Projected Need}} \times 100$$

is greater than 80 percent, then calculate projected need:

$$\text{Projected Need} = \frac{\text{Projected ADC}}{.8}$$

The Tennessee Department of Health's (TDH) report indicates there is a surplus of 1,455 acute care beds in the applicant's service area.

It appears that this criterion has not been met.

2. New hospital beds can be approved in excess of the "need standard for a county" if the following criteria are met:

a) All existing hospitals in the projected service area have an occupancy level greater than or equal to 80 percent for the most recent Joint Annual Report. Occupancy should be based on the number of licensed beds that are staffed for two consecutive years.

According to the 2013 Joint Annual Reports, there was one hospital in the applicant's service area that achieved 80% occupancy. The licensed bed occupancy for general acute care hospitals in the 8 county service area averaged 56% in 2013. (Source: 2013 Joint Annual Report).

It appears that this criterion has not been met.

b) All outstanding CON projects for new acute care beds in the proposed service area are licensed.

All approved new acute care beds are not licensed. Please refer to the Certificate of Need information at the end of the staff summary for a more detailed explanation.

Summit Medical Center (CN1402-004A) was approved at the May 28, 2014 meeting for the addition of 8 medical surgical beds which will increase the hospital's licensed bed complement from 188 to 196. However, the Division of Health Facilities, TDH, Licensed Facilities Report indicates the 8 approved surgical beds are not licensed. Vanderbilt University Hospitals was approved at the September 24, 2014 Agency meeting for the addition of 108 beds (23 obstetrical, 24 neonatal/pediatric critical care, and 61 adult acute care beds) which will increase the hospitals licensed bed complement from 1,025 to 1,159. The remaining "Outstanding CON" projects listed at the back of the summary involve relocated or converted beds in the service area with no net bed changes.

Since there are currently outstanding and unimplemented acute care beds in the service area, it appears that this criterion has not been met.

c) The Health Facilities Commission may give special consideration to acute care bed proposals for specialty health service units in tertiary care regional referral hospitals.

Special consideration is requested for the following reasons:

- *TriStar Centennial Medical Center is a tertiary care, regional referral hospital, draws patients from 92 counties and 9 states, and offers highly advanced care programs in multiple specialties.*
- *The proposed 7th floor 29-bed unit is a specialized nursing unit for a joint replacement program. The unit varies from other medical/surgical units in terms of 1) its restricted patient population; 2) oversized rooms; 3) patients are*

separated from infectious patients; and 4) its physical and operational integration with surgery, recovery, and rehab stages of care.

It appears that this criterion has been met.

SUMMARY

The following information is a summary of the original application and all supplemental responses. Any staff comments or notes, if applicable, will be in bold italics.

The project includes the development of a Joint Replacement Center of Excellence that will offer a centralized continuum of care including co-located patient intake and staging, 10 specialized operating rooms, recovery, and a unit of 29 additional licensed beds for post-surgical and rehabilitation of joint replacement patients. The Emergency Department located in the Tower will be completely renovated and remodeled to increase efficiency, which includes reducing treatment stations from 28 to 24. Construction is also required to improve support space related to elevators, mechanical, plumbing, and electrical systems.

An overview of the project is provided on pages 5-6 of the original application with highlights below.

Construction

The main hospital building includes an 8-floor patient tower. In order to accommodate the Joint Replacement Center of Excellence on Floors 7-8, a new 9th Floor will be constructed, including support space above Floor 9 to accommodate the mechanical powerhouse, helipad, and a patient entrance. The following chart reflects the proposed changes needed to accommodate the Joint Replacement Center of Excellence.

Proposed Changes –Floors 7-9				
Tower Floor	**Current**		**Proposed**	
	Beds	Services	Beds	Services
7th Floor (shelled North Wing)	33	Orthopedic Med/Surg Beds	33 + 29 62	Joint Replacement Program Med/Surg Beds
8th Floor	36	Med/Surg Beds	0	New Joint Replacement Surgery Intake Area (26 Staging Rooms)
8th Floor (new North Wing)	0	0	0	New Joint Replacement Surgery area (10 OR's, 15 Station Post-Anesthesia Care)
New 9th Floor	0	0	36	Relocate Med/Surg Beds from 8th floor
Total	69		98	

Changes by floor are as follows:

- 7th - Renovate and expand the 7th floor and add 29 new licensed beds.
- 8th - Relocate the existing 36 general medical-surgical beds to a newly constructed 9th floor; construct an intake and surgical staging area with 26 private staging rooms for pre-operative patient preparation; construct 10 ORs; and a 15 station PACU.
- 9th Floor- Construct a new 9th floor to house the 36 beds relocated the 8th Floor.

The following chart reflects the changes in bed assignments after the completion of the project.

Bed Type	Current Bed Assignment	Proposed Bed Assignment	+/-
Med/Surg	281	310	+29
Obstetrical/Gyn	75	75	0
Adult Critical Care	88	88	n/a
Neonatal Intensive Care	60	60	n/a
Pediatric	21	21	n/a
Psychiatric	132	132	n/a
Rehabilitation	0	0	0
Total	**657**	**686**	**+29**

Source: CN1406-032

Pages 7-10 of the original application contain a detailed description related to the Joint Replacement Program.

ED Tower Renovation

Three emergency departments are affiliated with CMC. Two are on campus- the main ED is in the Tower and there is also an ED at the Centennial Women's and Children's Hospital. A satellite ED is in Spring Hill in Maury County. This project is specific to the main ED in the Tower located on the north side of the ground floor of the main hospital building. The original ED had 14 treatment rooms. Two years ago the ED expanded into an adjoining vacant space as an overflow area adding 14 more treatment rooms. The purpose of the proposed project is to completely remodel both the original ED and the overflow area into one integrated, highly efficient ED with 24 treatment rooms.

A description of the complete remodel of the original Emergency Department and overflow space is included on page 11 of the original application. The addition of a dedicated CT scanner and other upgrades are also discussed. Tables 4-6 on pages 12 and 13 also include information regarding the renovation.

Miscellaneous Other Construction

The addition of patient rooms and new floors will require improvements in the elevators and in the mechanical, plumbing, and electrical systems of the hospital. A description is included on pages 11-12 of the original application.

Ownership

- TriStar Centennial Medical Center is wholly owned by HCA Health Services of Tennessee, Inc. whose ultimate parent company is HCA, Inc.
- HCA is composed of locally owned facilities that include approximately 190 hospitals and 82 outpatient surgery centers in 23 states, England and Switzerland.
- Centennial Medical Center is part of the locally managed HCA, Inc., which operates 14 hospitals and several surgery and imaging centers in Tennessee. An organizational chart is enclosed in Attachment A.4.

Facility Information

- TriStar Centennial Medical Center is a regional tertiary care referral facility for Middle Tennessee and Southern Kentucky.
- According to the TDH website, CMC is currently licensed for 657 beds. The 2013 Joint Annual Report indicates CMC was licensed for 657 beds

with 650 beds staffed. Licensed bed occupancy was 65.1% and staffed bed occupancy was 65.8%.

The following provides the Department of Health's definition of the two bed categories pertaining to occupancy information provided in the Joint Annual Reports:

- ***Licensed Beds - The maximum number of beds authorized by the appropriate state licensing (certifying) agency or regulated by a federal agency. This figure is broken down into adult and pediatric beds and licensed bassinets (neonatal intensive or intermediate care bassinets).***
- ***Staffed Beds - The total number of adult and pediatric beds set up, staffed and in use at the end of the reporting period. This number should be less than or equal to the number of licensed beds.***

Project Need

The applicant provides several reasons for the need of the project:

Joint Replacement Program Center of Excellence

- New physician group-Southern Joint Replacement Institute (SJRI), a Nashville physician group of four orthopedists specializing in joint replacement, will relocate its practice in November 2014 and will recruit a 5th physician by January 2015.
- Increased surgical caseloads- The additional caseloads brought by the new surgical staff will more than double existing caseloads.
- State of the art operating rooms-The ten new operating rooms will contain 625 square feet. Existing operating rooms in the Tower average 535 square feet. The larger rooms are needed to accommodate oversized operating tables and six person surgical teams.
- Continuum of Care-Consolidating joint replacement intake, surgery, recovery, and rehabilitation services in one area will lead to a better continuum of care, including reducing the risk of exposure to infection.
- An integrated Center of Excellence will optimize patient care and physician productivity.
- The applicant provides more details in pages 24-29 of the original application

Addition of Orthopedic Medical/Surgical Beds (29)

- The current medical-surgical inpatient bed occupancy is 87%.
- Medical staff expansion in 2015 will create an additional 1,500 joint replacement cases.

- Inpatient beds dedicated to the Joint Replacement Center are projected at 81.3% occupancy in Year 1 (2016) and 92.9% in Year 4 (2019).
- Most of the 29 private patient rooms will have 50 more square feet than the typical private room to allow for easier movement of patients with orthopedic appliances.
- The unit will also have its own rehabilitation gym with features such as training car/vehicle, a handicapped bathroom, and exercise mats not currently available in the Tower's existing rehabilitation space.
- The applicant provides more details in pages 24-29 of the original application

Main Emergency Department

- Renovations are needed to improve workflows, patient privacy, ambulance access, psychiatric emergency space, and to lessen patient transport to other parts of the hospital for diagnostic testing
- The number of exam/treatment rooms will decrease from 28 to 24 but ED square footage will increase by 5,260 square feet from 12,870 SF to 18,130 SF.
- In 2014, the Emergency Department is projected to serve 36,926 patients; in Year 2 of the proposed project, the updated ED is projected to serve 42,746 patients or 1,781 visits/treatment room. The applicant cites a planning guide developed by the American College of Emergency Physicians that indicates that an emergency room with 40,000 visits should have treatment rooms in the 25-33 range or 1,200-1,600 visits/treatment room; however, HCA has its own programming standard of 1,800-2,000 visits/treatment room.
- The project includes the addition of a CT scanner currently not available in the ED.
- The applicant provides more details in pages 20-23 of the original application

Service Area Demographics

CMC's declared primary service area includes Cheatham, Davidson, Montgomery, Robertson, Rutherford, Sumner, Williamson, and Wilson Counties.

- The total population of the 8 County Tennessee service area is estimated at 1,747,118 residents in calendar year (CY) 2014 increasing by approximately 6.9% to 1,867,569 residents in CY 2018.
- The overall Tennessee statewide population is projected to grow by 3.7% from 2014 to 2018.
- The 65 and older population in the service area will increase from 11.3% of the general population in 2014 to 12.4% in 2018. The statewide 65 and

older population will increase from 14.9% in 2014 of the general population to 16.1% in 2018.

- The latest 2014 percentage of the proposed primary service area population enrolled in the TennCare program is approximately 14.1% in the service area as compared to the statewide enrollment proportion of 18.4%.

Service Area Historical Utilization

2011-2013 Service Area Acute Care Hospital Utilization Trends

Facility	2013 Licensed Beds	2013 Staffed Beds	2013 Licensed Occupancy	2011 Patient Days	2012 Patient Days	2013 Patient Days	11-13 % Change
Tri-Star Hospitals							
Centennial Medical Center	657	650	65.1%	139,114	147,903	156,094	+12.2%
Centennial Med Ctr. Ashland City	12	12	31.0%	1,567	1,551	1,397	-10.8%
Hendersonville Medical Center	110	96	51.2%	18,732	20,434	20,567	+9.8%
Southern Hills Medical Center	126	81	43.6%	15,693	17,845	20,068	+27.8%
StoneCrest Medical Center	101	101	40.9%	14,082	15,472	16,254	+15.4%
Summit Medical Center	188	137	62.8%	39,877	42,722	43,122	+8.1%
Skyline Medical Center -Main	213	209	71.8%	51,710	52,021	55,811	+7.9%
Skyline Medical Center -Madison	172	108	43.2%	27,321	26,727	27,122	-0.7%
Sub-Total	**1,579**	**1,394**	**61.0%**	**308,096**	**324,675**	**340,435**	**+10.5%**
Gateway Medical Center	270	220	37.1%	43,753	41,483	36,609	-16.3%
McFarland Specialty Hospital	75	75	36.0%	12,372	10,813	9,864	-20.3%
Metro Nashville General Hospital	150	116	29.4%	21,027	17,401	16,088	-23.5%
NorthCrest Medical Center	109	66	35.0%	17,535	15,747	13,916	-20%
Saint Thomas Hospital Midtown	683	453	44.3%	113,135	112,163	110,408	-2.4%
St. Thomas Rutherford	286	268	60.8%	69,118	65,205	63,503	-5.2%
Saint Thomas West Hospital	541	404	50.6%	102,534	100,202	99,877	-2.6%
Sumner Regional Medical Center	155	117	57.8%	26,274	27,948	32,682	+24.4%
The Center for Spinal Surgery	23	23	17.7%	1,505	1,519	1,485	-1.3%
University Medical Center	170	170	36.1%	25,679	24,279	22,423	-12.7%
Vanderbilt University Medical Ctr.	985	966	80.3%	275,500	275,013	298,505	+8.4%
Williamson Medical Center	185	185	44.7%	33,241	31,518	30,171	-9.2%
Sub-Total	**3,632**	**3,063**	**54.7%**	**741,673**	**723,291**	**735,531**	**-0.8%**
TOTAL	**5,211**	**4,467**	**56.0%**	**1,049,769**	**1,047,966**	**1,075,966**	**+2.5%**

Source: CN1407-032 and JARs 2011-2013

The chart above reflects the following:

- Inpatient days in the 8 county service area increased 2.5% from 1,049,769 patient days in 2011 to 1,075,966 patient days in 2013.
- CMC inpatient days increased 12.2% from 139,114 in 2011 to 156,094 in 2013.

- All TriStar Hospitals in the service area had increased patient days of 10.5% during the same time period.
- Other service area hospitals experienced an overall decline in patient days of 0.8%
- According to the 2013 JAR there were 5,211 licensed acute hospital beds in the service area while 4,467 beds were staffed resulting in 744 licensed unstaffed beds in the service area.
- TriStar hospitals in the service area reported 1,579 licensed hospital beds in 2013 and 1,394 staffed beds resulting in 185 licensed unstaffed beds.
- CMC's licensed beds represented 12.6% of all licensed beds in the 8 County service area.
- Area wide licensed occupancies averaged 56.0% in 2013.
- TriStar area hospitals average occupancy overall was 61.0%
- CMC's share of patient days at service area hospitals increased from 13.3% in 2011 to 14.5% in 2013.
- Only one area hospital attained an occupancy rate of 80% or higher in 2013, Vanderbilt University Medical Center. One hospital attained an occupancy rate of 70%, Skyline Medical Center-Main. Three hospitals attained occupancy greater than 60%. Three hospitals attained occupancy of 50%, resulting in twelve hospitals with licensed occupancies of less than 50%.

Note to Agency members: The formula used to project acute care bed need demonstrates a 1,455 acute care bed surplus in the service area. Since 6 of the 8 hospitals within the TriStar system in Middle Tennessee reported a total of 185 unstaffed licensed beds, the applicant was asked to consider de-licensing 29 medical surgical beds at another facility under common ownership so as not to add more acute beds to an area that is already over-bedded. On page 5 of the supplemental response, the applicant identifies Skyline-Madison as the only campus where beds could be de-licensed, addresses why it believes de-licensing beds is not a viable option, and also notes why its request for additional beds should be considered under the exception provided in the criteria and standards for a "specialty unit" in a tertiary care referral hospital (Item 2c, Acute Care Bed Need Services).

Applicant's Historical and Projected Utilization

Historical and projected occupancy volumes for Centennial Medical Center, Emergency Department, and Joint Replacement Center are provided in the application. Historic and projected trends are displayed in the table below:

CMC Historical and Projected Utilization of Select Services Relevant to Proposed Project

CMC	2011	2012	2013	2014	2015	Proposed Project Year 1 2016	Proposed Project Year 2 2017
Licensed Beds	606	657	657	657	657	686	686
% Occ. (Inpatient Days Only)	62.9%	61.5%	65.1%	68.5%	73.7%	74.4%	79.0%
% Occ. (Includes Observation Days)	66.1%	68.7%	71.7%	76.1%	81.6%	82.3%	87.3%
Med/Surg Beds% Occ. (Inpatient Days Only)	67.8%	66.0%	70.6%	73.3%	81.8%	78.2%	82.4%
Med/Surg Beds % Occ. (Includes Observation Days)	73.9%	79.2%	82.8%	87.3%	96.2%	91.7%	96.5%
Emergency Department Patients	27,482	31,124	35,168	36,926	38,772	40,711	42,746
Joint Replacement Center (Cases)			1,150	1,196	2,744	2,869	2,999
Cases/Room			115	120	274	287	300
Tower Cases (Inc. Joint Replacement)	8,461	7,943	8,071	8,113	9,942	10,667	11,467
Cases/Room	498	467	475	477	585	395	425
Total Cases	18,378	19,502	20,792	21,757	24,287	25,761	27,332
Cases/Room	497	454	484	506	552	477	506

Source: CN1407-032

- The overall projected bed occupancy based on inpatient days only in Year 1 (2016) and Year 2 (2017) of the proposed project will average 74.4% and 79.0%, respectively.
- The overall projected bed occupancy including observation days in Year 1 (2016) and Year 2 (2017) of the proposed project will average 82.3% and 87.3%, respectively.
- The CMC emergency department patient volume will increase 48% from 27,482 patients in 2011 to 40,711 in Year 1 of the proposed project.
- Joint Replacement Cases will increase 149% from 1,150 in 2013 to 2,869 in Year 1 (2016) of the proposed project. The ten operating rooms are projected to be utilized 95% of the first three weekdays in the week so that patients are able to begin rehabilitation before the weekend; however

based on 5 days per week, the ten OR utilization rate is expected to be in the 50% range.

- By the second year of operation, the Joint Replacement ORs are expected to perform on average 300 cases per room annually. This compares to 506 cases per room for all Tower ORs.

Note to Agency Members: In the supplemental response, the applicant indicates the initial Physician Services Agreement with SJRI is for 5 years. SJRI is projected to move its practice office to the Physician's Park Medical Office in November 2014. The SJRI practice office has been consolidated at Saint Thomas West Hospital since 2007. The cases projected to transition to Centennial Medical Center, according to SJRI, are presently being performed at Saint Thomas Hospital West. According to the 2013 Joint Annual Report, the 1,500 cases slated to move to CMC represents 12.7% of the 11,779 total cases performed by Saint Thomas West.

CMC 2013 SURGICAL CASE CAPACITY AND UTILIZATION

Operating Rooms	# of Rooms	Minutes Used	Schedulable Minutes	% Time Used*
Total	43	2,478,207	5,160,000	48.0%
Tower	17	1,029,719	2,040,000	50.5%

Source: CN1407-032
*Does not include turnaround time

- Not including turnaround time, the surgical suites at CMC were at 48% capacity in 2013 and estimated to be at 49.9% in 2014
- Not including turnaround time, the surgical suites in the Tower, where orthopedic cases are currently taking place, were at 50.5% capacity in 2013 and estimated to be at 50.8% in 2014

Note to Agency members: With Operating Suites currently at less than 50% capacity, Agency members may want to inquire if other more cost-effective alternatives were considered. The applicant did note that current ORs are undersized and that there is no other location on campus for a comprehensive Joint Replacement Program.

Project Cost

The total estimated project cost is $96,192,007.00. Major costs are:

- Construction Costs plus contingencies -$58,209,318 or 60.5% of total cost
- Moveable equipment -$20,601,893 or 21.4% of the total cost

- Average total construction cost is expected to be $298.66 per square foot. The third quartile for cost per square foot of previously approved hospital projects from 2011-2013 was $274.63. The applicant states that the reasons for the higher cost include the need to stage the renovation and construction in phases in all the areas (emergency room; medical-surgical units) where patient care is being provided continuously.
- For other details on Project Cost, see the Project Cost Chart on page 61 of the original application.

Historical Data Chart

- According to the Historical Data Chart, Centennial Medical Center reported favorable net operating income (NOI) for the three most recent fiscal years: $38,829,000 for 2011; $38,775,724 for 2012; and $46,665,365 for 2013.
- As a percent of net operating revenue, NOI was 8.3% in 2011, 8.6% in 2012, and 8.3% in 2013.

Projected Data Chart

The applicant provided a Projected Data Chart for Centennial Medical Center, CMC Main Emergency Department, and the Joint Replacement Center of Excellence (includes operating suite, 29 beds, and all service within the unit). Key highlights of the hospital's projected financial performance are as follows:

Centennial Medical Center

- 186,299 inpatient discharges are projected in Year 2016 increasing to 197,886 in Year 2017.
- Net operating income less capital expenditures will equal $63,228,366 in Year 2016 increasing to $69,900,434 in Year 2017.

CMC Main Emergency Department

- 40,711 emergency department patients are projected in Year 2016 increasing to 42,746 in Year 2017.
- Net operating income less capital expenditures will equal $8,213,825 in Year 2016 increasing to $9,127,475 in Year 2017.

Joint Replacement Center

- 2,869 inpatient discharges are projected in Year 2016 increasing to 2,999 in Year 2017.
- Net operating income less capital expenditures will equal $1,388,648 in Year 2016 decreasing to $928,324 in Year 2017.

Charges

In Year 1 of the proposed project, the average charge per case is as follows:

CMC Main Emergency Department

Average Gross Charge

- $4,243

Average Deduction from Operating Revenue

- $3,540

Average Net Charge

- $703

Joint Replacement Center

Average Gross Charge per Discharge

- $101,333

Average Deduction from Operating Revenue per Discharge

- $80,077

Average Net Charge per Discharge

- $21,256

Payer Mix

- The applicant indicates it has contracts with all three TennCare MCOs available to its service area population: United HealthCare Community Plan (formerly AmeriChoice), TennCare Select and AmeriGroup.
- The CMC Emergency Department projects $38,002,090 in Medicare gross revenue and $57,003,135 in TennCare gross revenue in Year 1. These amounts equate to approximately 22% and 33%, respectively, of total gross operating revenue in Year 1.
- The CMC Joint Replacement Program projects $165,713,157 in Medicare gross revenue and $20,350,739 in TennCare gross revenue in Year 1. These amounts equate to approximately 57% and 7%, respectively, of total gross operating revenue in Year 1.

Note to Agency Members: Southern Joint Replacement Institute's (SJRI) Blue Cross/Blue Shield (BCBS) payer mix is approximately 26%, of which less than ½ is under the BCBS S Plan. Centennial Medical Center is not a participant. If approved, any BCBS S plan participant requiring hospital-based joint replacement services will either have to pay out-of- network, which is unlikely, or be served by in-network facilities. The applicant points out in the supplemental response that the estimated relocation of 1,500 cases excluded SJRI's BCBS S Plan and assumes that SJRI's S Plan enrollees will continue to be served at facilities other than CMC. The 1,500 cases represent approximately 75% of SJRI cases at all locations.

Financing

- The source of funding for the project is identified as a cash transfer from the applicant's parent (HCA, Inc.) to the applicant's division office (TriStar Health System).
- A July 10, 2014 letter signed by the President and Chief Financial Officer of TriStar Health System attests to HCA's ability to finance the project.
- Review of the HCA's Holdings financial statement as of 12/31/13 revealed cash and cash equivalents of $414,000,000, current assets of $8,037,000,000 and current liabilities of $5,695,000,000 for a current ratio of 1.41 to 1.0.

  Note to Agency Members: Current ratio is a measure of liquidity and is the ratio of current assets to current liabilities, which measures the ability of an entity to cover its current liabilities with its existing current assets. A ratio of 1:1 would be required to have the minimum amount of assets needed to cover current liabilities.

Staffing

- Staffing of the Emergency and the Med/Surgical departments at CMC's is expected to increase from 585 current full time equivalent staff (FTE) to 703 FTE in Year 1 and 728 FTE in Year 2.
- Please refer to Table Twenty-B on page 84 of the original application for an overview of the current and projected staffing of the proposed project.

Licensure/Accreditation

Centennial Medical Center is licensed by the Tennessee Department of Health and accredited by The Joint Commission. A copy of the most recent inspection by The Joint Commission is located in Attachment C, Orderly Development-7 (c).

The applicant has submitted the required corporate documentation, site control documents, and miscellaneous information pertaining to the demographics of the primary service area. Staff will have a copy of these documents available for member reference at the meeting. Copies are also available for review at the Health Services and Development Agency office.

Should the Agency vote to approve this project, the CON would expire in three years.

CERTIFICATE OF NEED INFORMATION FOR THE APPLICANT:

There are no other Letters of Intent, denied or pending applications, or outstanding certificates of Need for this applicant.

HCA has financial interests in this project and the following:

Denied Applications:

Summit Medical Center, CN1206-029D, was denied at the September 26, 2012 Agency meeting. The application was for the for the establishment of a 20 bed acute inpatient rehab unit and service in its hospital facility by converting 20 adult psychiatric beds and reclassifying the adult psychiatric unit to an inpatient rehab unit. The estimated cost was projected to be **$2,500,000.00** *Reason for Denial: the application did not meet the statutory criteria.*

Pending Applications

Parkridge Medical Center, CN1408-035, has a pending application that will be heard at the November 19, 2014 Agency meeting for a Certificate of Need for the acquisition of a second magnetic resonance imaging (MRI) unit for installation and use in 1,202 square feet of renovated space on the main campus of Parkridge Medical Center (PMC) at 2333 McCallie Avenue, Chattanooga (Hamilton County), TN. The estimated project cost is **$2,968,942.00.**

Outstanding Certificates of Need

Skyline Medical Center, CN1406-020A, has an outstanding Certificate of Need that will expire on November 1, 2017. It was approved at the September 24, 2014 Agency meeting to increase the licensed bed capacity at the hospital's campus by 10 beds. The beds will be utilized as medical-surgical and intensive care beds. The beds will be added by renovating existing space at the main campus which is located at 3441 Dickerson Pike, Nashville (Davidson County), TN. Simultaneously, 10 licensed beds will be closed at the Skyline satellite campus at 500 Hospital Drive, Madison (Davidson County), TN. TriStar Skyline Medical Center is currently licensed as an acute care hospital with 385 hospital beds. This project will increase beds at the main campus from 213 to 223 beds, and will reduce the satellite campus from 172 to 162 beds, so that the consolidated 385-bed licensed will not change. The estimated project cost is **$3,951,732.00.** *Project status update: This project was recently approved.*

Summit Medical Center, CN1402-004A, has an outstanding Certificate of Need that will expire on July 1, 2017. It was approved at the May 28, 2014 Agency meeting for the addition of eight (8) medical/surgical beds increasing the hospital's licensed bed complement from one hundred eighty-eight (188) to one hundred ninety-six (196) total licensed beds. The new beds will be located in renovated space on the 7th Floor of the hospital in space to be vacated by the

hospital's Sleep Lab which will be relocated to the adjacent Medical Office Building on the hospital campus. The estimated project cost is **$1,812,402.00.** *Project Status Update: The project was recently approved.*

Hendersonville Medical Center, CN1302-002A, has an outstanding Certificate of Need that will expire on August 1, 2016. It was approved at the June 26, 2013 Agency meeting to construct a new fourth floor of medical surgical beds and initiate Level IIB Neonatal Intensive Care services in a new six (6) licensed bed Level IIB Neonatal Intensive Care Unit (NICU) on its campus at 355 New Shackle Island Road, Hendersonville (Sumner County) Tennessee, 37075. The proposed project will not change the total licensed bed complement. The hospital currently holds a single consolidated license for 148 general hospital beds, of which 110 are located at its main Hendersonville campus and 38 are located at its satellite campus at 105 Redbud Drive, Portland (Sumner County), TN 37148. The applicant will relocate 13 beds from the satellite campus to the main campus, resulting in 123 licensed beds at the Hendersonville campus and 25 licensed beds at the Portland satellite campus. The estimated cost of the project is **$32,255,000.00.** *Project Status: per 5/12/14 e-mail, the Chief Operations Officer of the medical center advised that the hospital is in process of finishing design drawings over the next 90 -120 days. Once approved, construction is expected to begin in early 2015.*

Natchez Surgery Center, CN1002-011A, has an outstanding Certificate of Need that will expire on July 1, 2015. It was approved at the May 26, 2010 Agency meeting for the establishment of an ambulatory surgical treatment center (ASTC) with three (3) operating rooms and three (3) procedure rooms. After approval, CN801-001A was surrendered which was a similar facility for this site at 107 Natchez Park Drive, Dickson (Dickson County), TN. The estimated cost of the project was **$13,073,892.00.** *Project Status: the applicant requested a modification at the March 2012 Agency meeting to extend the expiration date for three (3) years from July 1, 2012 to July 1, 2015; reduce the number of operating rooms from three (3) to two (2) and procedure rooms from three (3) to one (1); reduce project costs by $4,201,823 from $13,073,892 to $8,872,069; and reduce square footage by 4,965 from 15,424 to 10,459 square feet. The Agency voted to defer consideration of this request until the May 2012 meeting so that it could be heard simultaneously with CN1202-008, Horizon Medical Center Emergency Department. Both CN1202-008 and the modification to CN1002-011A were approved at the May 2012 meeting. According to a 4/25/14 e-mail from a representative of HCA Healthcare, groundbreaking did not occur in December 2013 but the project is well underway. Architectural plans will be submitted to the state for approval the week of 5/5/2014 and plans will be released for bidding. The new groundbreaking date subject to state approval is June/July 2014. The ASTC project will require a seven month construction period with an anticipated opening date of January/February 2015.*

Parkridge Valley Hospital, CN1202-006AM has an outstanding Certificate of Need that will expire on July 1, 2015. The CON was approved at the May 23, 2012 Agency meeting for (1) the addition of sixteen (16) additional child and adolescent psychiatric beds to the sixty-eight (68) beds currently located on the satellite campus at 2200 Morris Hill Road, Chattanooga (Hamilton County) and (2) the relocation of all forty-eight (48) of its licensed adult psychiatric beds to a new campus. The current licensed hospital bed complement at Parkridge Valley Hospital, which is a satellite location of Parkridge Medical Center, will decrease from one hundred sixteen (116) beds to eighty-four (84) beds. The net result of this application is that only child and adolescent psychiatric beds will operate at this location. The estimated project cost of **$143,000.** *Project Status Update: the project cost was modified at the January 22, 2014 Agency meeting to a revised amount of* **$706,006.** *An e-mail was received on 4/25/14 from a representative of Parkridge indicating that Phase 1 of the Parkridge Valley Child & Adolescent campus construction (re-configuring space and moving walls), has been completed with the result that the number of patients who are housed three to a room has been reduced. Phase 2 involves the conversion of adult space to space appropriate for children and adolescents, including the conversion to all semi-private rooms in accordance with the industry norm of no more than two adolescents per room. Currently, architectural drawings are in the process of being finalized for review and approval by the Division of Health Care Facilities, Tennessee Department of Health. Parkridge expects to begin Phase 2 in early summer of 2014 with construction expected for a period of approximately 12 weeks. The representative stated that Parkridge is on track to complete the project within the $706,006 project cost estimate by the expiration date of July 1, 2015.*

Horizon Medical Center Emergency Department, CN1202-008A, has an outstanding Certificate of Need that will expire on July 1, 2015. The CON was approved at the May 23, 2012 Agency meeting to establish a satellite emergency department facility located at its Natchez Medical Park campus located at 109 Natchez Park Drive, Dickson (Dickson County). Estimated project cost is **$7,475,395.** *Project Status Update: according to a 4/25/14 e-mail from a representative of HCA Healthcare, the project is well underway. Architectural plans will be submitted to the state for approval the week of 5/5/2014 and plans will be released for bidding. The new groundbreaking date subject to state approval is June/July 2014. The ASTC project will require a seven month construction period with an anticipated opening date of January/February 2015.*

CERTIFICATE OF NEED INFORMATION FOR OTHER SERVICE AREA FACILITIES:

There are no other Letters of Intent, denied or pending applications for other health care organizations proposing this type of service.

Outstanding Certificates of Need:

Vanderbilt University Hospitals, CN1406-021A, has an outstanding Certificate of Need that will expire on November 1, 2017. The CON was approved at the September 24, 2014 Agency meeting for the relocation of the obstetrical program, the newborn nursery, and the neonatal unit from Vanderbilt University Hospital to Monroe Carell Jr. Children's Hospital, the addition of 23 obstetrical beds and 24 neonatal/pediatric critical care beds, the addition of 61 adult acute care beds, the renovation of 79,873 square feet and new construction of 126,686 square feet. The estimated total project cost is **$118,276,950.00.** *Project status update: This project was recently approved.*

Saint Thomas Hospital-Midtown, CN1401-001A, has an outstanding Certificate of Need that will expire on June 1, 2017. The application was approved at the April 23, 2014 Agency meeting for the development of a Joint Replacement Service by consolidating orthopedic operating rooms currently located on two different floors of STM and by relocating operating rooms (OR) at Saint Thomas West Hospital to STM. The service will contain ten (10) surgical joint replacement suites, PACU and Prep/Recovery private bay areas, and two (2) dedicated nursing units with a total of 62 private patient rooms. There will be no net increase to the OR complement of Saint Thomas Health – Nashville if the OR complement in Saint Thomas Hospital, CN110-037A is voluntarily reduced by 4 ORs. This project will not change the hospital's 683 licensed bed complement. The total estimated project cost is **$25,832,609.** *Project status update: This project was recently approved.*

Williamson County Hospital District d/b/a Williamson Medical Center, CN1210-048A, has an outstanding Certificate of Need which will expire on March 1, 2017. It was approved at the January 23, 2013 Agency meeting for the construction and renovation project that will renovate and expand surgery and surgery support areas on the east side of the main hospital building and construct a three-story addition on the west side of the main hospital building for pediatric services and shelled space for future relocation of obstetrics services. The estimated project cost is **$67,556,801.00.** *Project Status: A 9/9/2014 email from a representative of Williamson Medical Center indicated site work is complete and the project is currently on schedule and within budget.*

Saint Thomas Medical Center, CN1110-037A, has an outstanding certificate of need that will expire on March 1, 2017. The application was approved at the January 25, 2012 Agency meeting for the 3-phase hospital renewal project for various services and area: renovation of 89,134 SF of hospital space; construction an adjoined 6-level 135,537 SF patient tower; and the addition of a GE Discovery CT scanner. The estimated project cost is **$110,780,000.** *Project Status update:*

Review of the 4/2/14 annual progress report revealed that Phase 1 of the project (renovations to the second floor ICU rooms) is 100% complete, with review by TDH occurring in March 2014. The OR renovations and Emergency Department CT are currently in construction ahead of schedule and are at 5% and 15% completion, respectively. Phase 2 work (new tower construction) is scheduled to begin mid/late-2014 and some Phase 3 work (reconfiguration of space that is not dependent on relocation of services to the new tower) is planned to start in the next several months. The overall project is expected to be complete in early 2017.

Vanderbilt Medical Center, CN0606-037A, has an outstanding certificate of need that will expire on July 1, 2015. The CON was approved at the September 27, 2006 Agency meeting for the continuance of facility's master plan: addition of 3rd bed tower with redistribution of 141 SNF beds to 141 new acute care beds; renovation and expansion of cardiac cath labs and hybrid ORs; addition of 14 newly constructed OR suites; and decommissioning 2 ORs. **The estimated project cost is $234,421,471.00.** *Project Status Update: according to the Annual Progress Report submitted on July 1, 2014, all bed floors have been completed, licensed and are in service. The 5th floor, including the relocated cardiac catheterization and EP labs, was completed in January 2014. The hospital expects to submit its final project report with documentation of final expenditures prior to the expiration date of July 1, 2015.*

PLEASE REFER TO THE REPORT BY THE DEPARTMENT OF HEALTH, DIVISION OF HEALTH STATISTICS, FOR A DETAILED ANALYSIS OF THE STATUTORY CRITERIA OF NEED, ECONOMIC FEASIBILITY, AND CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTH CARE IN THE AREA FOR THIS PROJECT. THAT REPORT IS ATTACHED TO THIS SUMMARY IMMEDIATELY FOLLOWING THE COLOR DIVIDER PAGE.

PME
(10/9/2014)

LETTER OF INTENT

LETTER OF INTENT -- HEALTH SERVICES & DEVELOPMENT AGENCY

The Publication of Intent is to be published in the Nashville Tennessean, which is a newspaper of general circulation in Davidson County, Tennessee, on or before July 10, 2014, for one day.

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. Sections 68-11-1601 et seq., and the Rules of the Health Services and Development Agency, that TriStar Centennial Medical Center, a hospital, owned and managed by HCA Health Services of Tennessee, Inc., a corporation, intends to file an application for a Certificate of Need to renovate its main Emergency Department; to develop a Joint Replacement Center of Excellence that will include ten (10) additional operating rooms; and to increase the hospital's licensed bed complement. These will take place at its main hospital facility at 2300 Patterson Street, Nashville, TN 37203, at a capital cost estimated at $94,000,000.

Centennial is licensed as a 657-bed acute care hospital by the Board for Licensing Health Care Facilities. The project will increase Centennial's total licensed bed complement to 686 beds, an increase of 29 beds. The project includes a CT scanner for the Emergency Department, but does not include major medical equipment, or initiate or discontinue any health service.

The anticipated date of filing the application is on or before July 15, 2014. The contact person for the project is John Wellborn, who may be reached at Development Support Group, 4219 Hillsboro Road, Suite 210, Nashville, TN 37215; (615) 665-2022.

John K Wellborn 7-8-14 jwdsg@comcast.net

(Signature) (Date) (E-mail Address)

ORIGINAL APPLICATION

CENTENNIAL MEDICAL CENTER NASHVILLE

CERTIFICATE OF NEED APPLICATION TO DEVELOP A JOINT REPLACEMENT CENTER OF EXCELLENCE, TO REMODEL THE HOSPITAL'S EMERGENCY DEPARTMENT, AND TO REPLACE AND ADD LICENSED BEDS

Filed July 15, 2014

PART A

1. *Name of Facility, Agency, or Institution*

TriStar Centennial Medical Center		
Name		
2300 Patterson Street		Davidson
Street or Route		*County*
Nashville	TN	37203
City	*State*	*Zip Code*

2. *Contact Person Available for Responses to Questions*

John Wellborn		Consultant	
Name		*Title*	
Development Support Group		jwdsg@comcast.net	
Company Name		*E-Mail Address*	
4219 Hillsboro Road, Suite 210	Nashville	TN	37215
Street or Route	*City*	*State*	*Zip Code*
CON Consultant	615-665-2022	615-665-2042	
Association With Owner	*Phone Number*	*Fax Number*	

3. *Owner of the Facility, Agency, or Institution*

HCA Health Services of Tennessee, Inc.		
Name		
2300 Patterson Street		Davidson
Street or Route		*County*
Nashville	TN	37203
City	*State*	*Zip Code*

4. *Type of Ownership or Control (Check One)*

A. Sole Proprietorship		F. Government (State of TN or Political Subdivision)	
B. Partnership		G. Joint Venture	
C. Limited Partnership		H. Limited Liability Company	
D. Corporation (For-Profit)	x	I. Other (Specify):	
E. Corporation (Not-for-Profit)			

PUT ALL ATTACHMENTS AT THE BACK OF THE APPLICATION IN ORDER AND REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS

5. *Name of Management/Operating Entity (If Applicable)* NA

Name
Street or Route — *County*
City — *State* — *Zip Code*

6. *Legal Interest in the Site of the Institution (Check One)*

A. Ownership	x	D. Option to Lease	
B. Option to Purchase		E. Other (Specify):	
C. Lease of ____ Years			

7. *Type of Institution (Check as appropriate—more than one may apply)*

A. Hospital (Specify): General	x	I. Nursing Home	
B. Ambulatory Surgical Treatment Center (ASTC) Multi-Specialty		J. Outpatient Diagnostic Center	
C. ASTC, Single Specialty		K. Recuperation Center	
D. Home Health Agency		L. Rehabilitation Center	
E. Hospice		M. Residential Hospice	
F. Mental Health Hospital		N. Non-Residential Methadone	
G. Mental Health Residential Faclity		O. Birthing Center	
H. Mental Retardation Institutional Habilitation Facility (ICF/MR)		P. Other Outpatient Facility (Specify):	
		Q. Other (Specify):	

8. *Purpose of Review (Check as appropriate—more than one may apply*

A. New Institution		G. Change in Bed Complement Please underline the type of Change: Increase, Decrease, Designation, Distribution, Conversion, Relocation	x
B. Replacement/Existing Facility		H. Change of Location	
C. Modification/Existing Facility	x	I. Other (Specify):	
D. Initiation of Health Care Service as defined in TCA Sec 68-11-1607(4) (Specify)			
E. Discontinuance of OB Service			
F. Acquisition of Equipment			

9. *Bed Complement Data*

(Please indicate current and proposed distribution and certification of facility beds.)

	Current Licensed Beds	CON approved beds (not in service)	Staffed Beds	Beds Proposed (Change)	TOTAL Beds at Completion
A&B: Medical-Surgical	281	0	281	+29	310
C. Long Term Care Hosp.					
D. Obstetrical/Gyn	75	0	75	0	75
E. ICU/CCU	88	0	88	0	88
F. Neonatal	60	0	60	0	60
G. Pediatric	21	0	21	0	21
H. Adult Psychiatric	116	0	116	0	116
I. Geriatric Psychiatric	16	0	16	0	16
J. Child/Adolesc. Psych.					
K. Rehabilitation					
L. Nursing Facility (non-Medicaid certified)					
M. Nursing Facility Lev. 1 (Medicaid only)					
N. Nursing Facility Lev. 2 (Medicare only)					
O Nursing Facility Lev. 2 (dually certified for Medicare & Medicaid)					
P. ICF/MR					
Q. Adult Chemical Dependency					
R. Child/Adolescent Chemical Dependency					
S. Swing Beds					
T. Mental Health Residential Treatment					
U. Residential Hospice					
TOTAL	**657**	**0**	**657**	**+29**	**686**

10. Medicare Provider Number:	0440161
Certification Type:	General Hospital
11. Medicaid Provider Number:	0440161
Certification Type:	General Hospital

12. & 13. See page 4

A.12. IF THIS IS A NEW FACILITY, WILL CERTIFICATION BE SOUGHT FOR MEDICARE AND/OR MEDICAID?

This is not a new facility. Centennial Medical Center is certified for both Medicare and TennCare/Medicaid.

A.13. IDENTIFY ALL TENNCARE MANAGED CARE ORGANIZATIONS / BEHAVIORAL HEALTH ORGANIZATIONS (MCO'S/BHO'S) OPERATING IN THE PROPOSED SERVICE AREA. WILL THIS PROJECT INVOLVE THE TREATMENT OF TENNCARE PARTICIPANTS? Yes IF THE RESPONSE TO THIS ITEM IS YES, PLEASE IDENTIFY ALL MCO'S WITH WHICH THE APPLICANT HAS CONTRACTED OR PLANS TO CONTRACT.

DISCUSS ANY OUT-OF-NETWORK RELATIONSHIPS IN PLACE WITH MCO'S/BHO'S IN THE AREA.

Centennial Medical Center is contracted through the HCA TriStar hospital system to all three Middle Tennessee TennCare MCO's. They are listed below in Table One. Centennial has already contracted with all three of the Statewide TennCare organizations that the TennCare Bureau will have in place by January 1, 2015.

Table One: Contractual Relationships with Service Area MCO's	
Available TennCare MCO's	**Applicant's Relationship**
AmeriGroup	contracted
United Healthcare Community Plan (formerly AmeriChoice)	contracted
TennCare Select	contracted

SECTION B: PROJECT DESCRIPTION

B.I. PROVIDE A BRIEF EXECUTIVE SUMMARY OF THE PROJECT NOT TO EXCEED TWO PAGES. TOPICS TO BE INCLUDED IN THE EXECUTIVE SUMMARY ARE A BRIEF DESCRIPTION OF PROPOSED SERVICES AND EQUIPMENT, OWNERSHIP STRUCTURE, SERVICE AREA, NEED, EXISTING RESOURCES, PROJECT COST, FUNDING, FINANCIAL FEASIBILITY AND STAFFING.

Proposed Services and Equipment

- TriStar Centennial Medical Center in Nashville is a regional tertiary care referral facility for Middle Tennessee and Southern Kentucky. Within its main hospital building ("The Tower"), it proposes to develop a Joint Replacement Center of Excellence. This will offer a centralized continuum of care that includes co-located patient intake and staging, 10 specialized operating rooms, recovery, and a unit of 29 additional licensed beds for post-surgical care and rehabilitation of Joint Replacement patients. It will require renovation and expansion of the Tower's seventh and eighth floors, and construction of a new ninth floor to house 36 medical-surgical beds being displaced from the eighth floor. The hospital's acute care bed complement at the campus will increase from 657 to 686 licensed beds.

- The hospital's Tower Emergency Room will be renovated to become more efficient, reducing treatment stations from 28 to 24, and replacing and adding equipment that includes a dedicated CT scanner for emergency patients.

Ownership Structure

- TriStar Centennial Medical Center is wholly owned by HCA Health Services of Tennessee, Inc. (the CON applicant in this project). That entity is wholly owned by HCA Holdings, Inc., the national healthcare system headquartered in Nashville. Attachment A.4 contains more details, an organization chart, and information on the Tennessee facilities owned by the applicant organization.

Service Area

- The primary service area for the hospital and the project is an eight-county area surrounding Nashville, where this project is located. It consists of Davidson County, and contiguous Cheatham, Montgomery, Robertson, Rutherford, Sumner, Williamson, and Wilson Counties. This area is expected to generate approximately 68% of the hospital's inpatient admissions and the admissions to this project.

Need

- In CY 2015, additions to TriStar Centennial's surgical staff will more than double the caseloads of its existing Joint Replacement program. The medical staff and hospital have determined to locate future Joint Replacement surgeries in a physically and operationally dedicated Center of Excellence that contains every step of the continuum of care for these patients. The objectives of this consolidation are to continuously improve outcomes and efficiency for this group of patients, achieving goals of quality and cost-effectiveness

through collaborative management by the hospital and its orthopedic surgeons. It will also remove these patients from most areas of the hospital where infectious patients are served; and it will make it easier for patients with joint pain to reach services within the hospital with minimal effort.

• The addition of 29 licensed orthopedic medical-surgical inpatient beds for this program is needed because current medical-surgical bed capacity at Centennial is at very high occupancies throughout the year (87%); and the 1,500 additional Joint Replacement cases projected to arrive with medical staff expansion in 2015 cannot be served in existing medical-surgical bed capacity. Ten new specialized operating rooms are needed to ensure that patients can complete their surgeries as early as possible in the week, so that they can begin rehabilitation before the weekend or can transfer to other post-acute environments before the weekend. These ten operating rooms are projected to be utilized at more than 95% the first three days of each week. The inpatient beds dedicated to the Center are projected to be at 81.3% occupancy in Year One (CY 2016) and 92.9% occupancy in Year Four (CY 2019).

• Renovation and updating of the main Emergency Department ("ED") and its equipment is needed to achieve more efficient workflows, lessen patient transport to other areas of the hospital for diagnostic tests such as CT scanning, provide more patient privacy and family counseling space, provide better rooms for psychiatric emergency patients, and to improve ambulance access. In CY 2014, the ED is conservatively projected to serve 36,128 patients (1,290 per treatment station); in Year Two of the project, CY 2017, the updated ED will be efficiently serving 41,823 patients (1,743 per treatment station). The proposed 24 stations are consistent with room complements recommended by the American College of Emergency Physicians, and also comply with HCA's own national planning standards for utilization per treatment room.

Existing Resources

• The service area contains 18 general acute care hospitals (excluding dedicated rehabilitation and psychiatric facilities). Davidson County contains 9 of these. The 18 hospitals as a group have averaged approximately 57% occupancy for the past three years, with individual occupancies ranging from 17.7% to 80.3% in CY 2013.

• Areawide ED data is not provided in this application because the update project will reduce, not expand, area ED capacity and area data are not relevant to an update.

Project Cost, Funding, Financial Feasibility, and Staffing

• The project cost is estimated at $96,192,007, all of which will be provided by the applicant's parent company, through its local Division office, TriStar Health System. The hospital has a positive cash flow and operating margin and this will continue with all phases of the project in operation.

• Staffing of the Medical-Surgical Department and the Emergency Department of TriStar Centennial Medical Center is projected to increase by 143.5 FTE's by Year Two of the project (CY2017), as medical-surgical and emergency services continue to expand at this regional tertiary referral facility.

B.II. PROVIDE A DETAILED NARRATIVE OF THE PROJECT BY ADDRESSING THE FOLLOWING ITEMS AS THEY RELATE TO THE PROPOSAL.

B.II.A. DESCRIBE THE CONSTRUCTION, MODIFICATION AND/OR RENOVATION OF THE FACILITY (EXCLUSIVE OF MAJOR MEDICAL EQUIPMENT COVERED BY T.C.A. 68-11-1601 *et seq.)* INCLUDING SQUARE FOOTAGE, MAJOR OPERATIONAL AREAS, ROOM CONFIGURATION, ETC.

This section describes the project's purposes and design features. Analysis of the need for the project is provided in Section B.II.C.

I. The Project--Physical Description

A. Development of a Joint Replacement Center of Excellence on the 7th and 8th Floors

CMC's main hospital building now has a Patient Tower that is eight floors in height. The Tower's 7th floor contains 33 medical-surgical beds, and has a shelled-in North Wing constructed for future bed additions. Its 8th floor contains 36 licensed medical-surgical beds, but does not have a North Wing. On the roof of the 8th floor are a helipad and patient entry and a mechanical powerhouse.

CMC proposes to renovate and expand the 7th and 8th floors of the Tower into a Center of Excellence for its rapidly growing Joint Replacement Program, whose cases will significantly increase in the near future due to increased surgical staff in late 2014. The project will provide the Joint Replacement Program with optimal surgical team productivity. It will increase O.R. capacity and surgical case throughput, ensuring that patients complete their complex surgeries early enough in the day and the week to have immediate access to post-surgical care and to initiate rehabilitation before the weekend. By concentrating them in one location, most of the Joint Replacement patients (who have joint pain, but are not ill or infectious) will be separated completely from the general hospital population, reducing the risks of exposing them to infection during their entire stay, from registration through discharge.

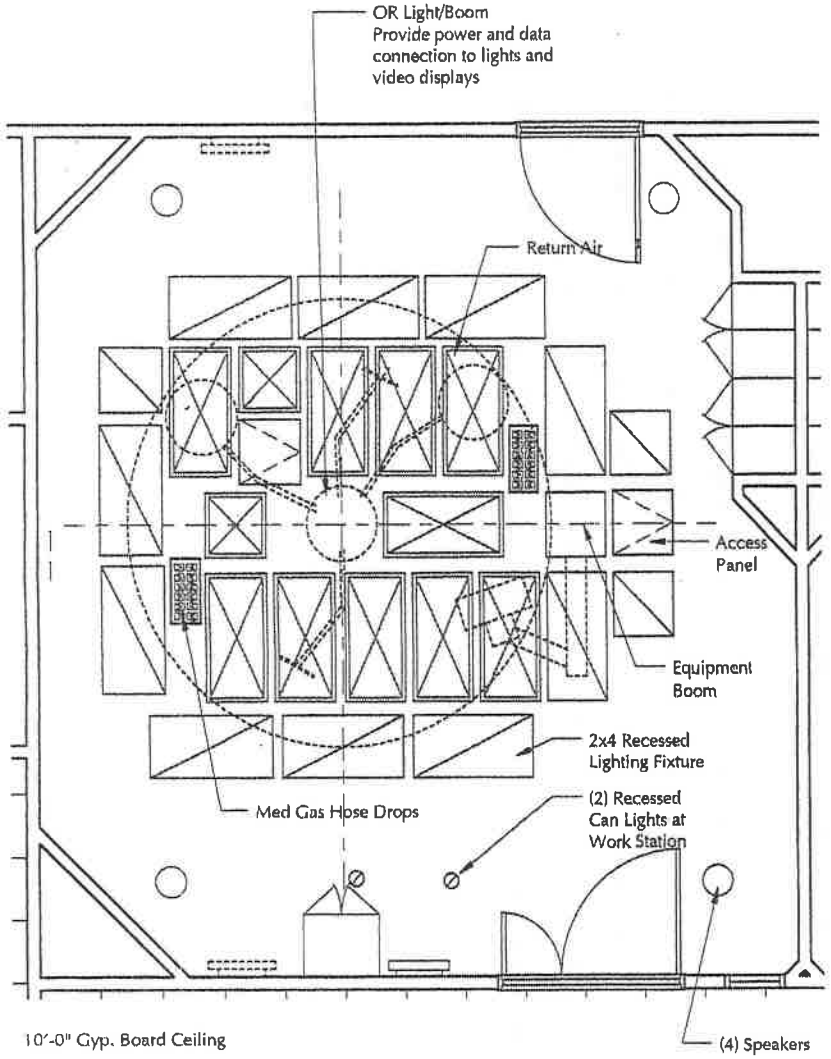
To develop the Center, CMC will relocate the 8th floor's 36 existing general medical-surgical beds to a newly constructed 9th floor. The motor lobby on the ground

floor will be renovated to provide a prominent entry for the Center. In the lobby, a set of elevators now running from the hospital's parking lobby up to the third floor cardiovascular area will be replaced with oversize elevators which will extend from the motor lobby up through the 8th floor, to provide direct access between patient parking and the Joint Replacement Center. Those two elevators will not stop on the 4th through 6th floors. This access plan minimizes the distances that patients with severe joint pain would have to walk within the campus and hospital, to get to their site of service.

In the vacated 8th floor space, CMC will construct a Joint Replacement Center intake area with patient reception and patient waiting, and a Surgical Staging Area of 26 private staging rooms (not licensed beds) for pre-operative preparation of patients.

Adjoining the Staging Area, a new North Wing will be added to the 8th floor. It will contain surgical and recovery facilities for the Joint Replacement program. The new wing will have ten (10) operating rooms, a 15-station Post-Anesthesia Care Unit ("PACU" or Recovery Unit), and related support spaces.

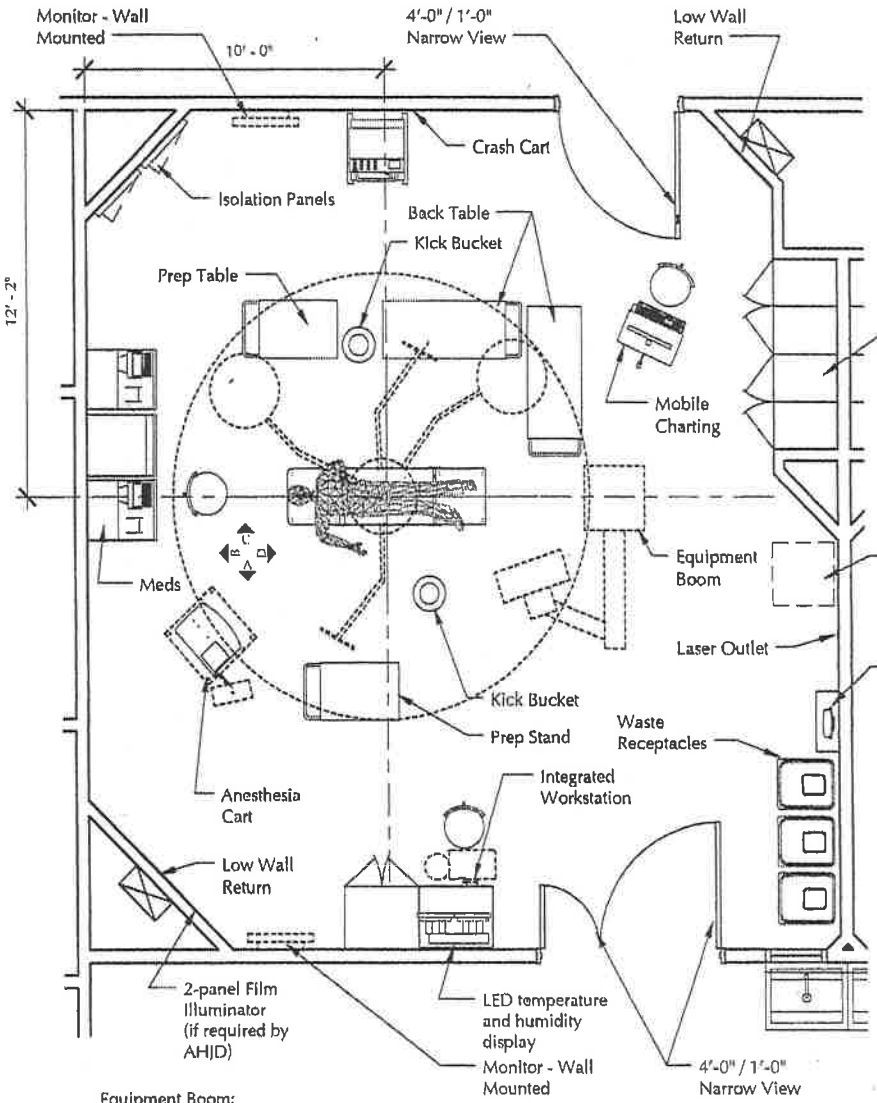
The operating rooms will be 625 SF in size. The other Tower operating rooms average 535 SF; and the two used currently for orthopedic cases including Joint Replacement average 471 SF. The larger operating rooms will provide space for Joint Replacement surgical teams of six persons and their equipment to work and to move efficiently around an oversize operating table, achieving the highest possible case productivity. A preliminary conceptual drawing of the new 625 SF operating room design is provided on the next page; it clearly shows the importance of providing this size of surgical room for this type of orthopedic case. (The operating room table in the drawing is not to scale; the Center will have much larger tables in every operating room.)



10'-0" Gyp. Board Ceiling

Med Gas Hose Drops:
(3) Emergency simplex outlets
PM2 (Data connection for Physiological monitoring
(2) Data outlets for phone and anesthesia cart connection
(2) Oxygen (1) Medical Air (1) Nitrous Oxide (1) WAG (1) VAC

OR 1 - Ceiling Plan



Equipment Boom:
(8) Emergency duplex outlets
(2) Normal duplex outlets
(2) Data outlets for phone and data connection
(3) VAC (1) Nitrogen with Regulator (1) CO2

OR 1 - Floor Plan 625 S.F. Clear

For post-recovery care and rehabilitation of Joint Replacement patients, CMC will build out 29 new private patient rooms in the existing shelled North Wing on the 7th floor immediately below the 8th floor operating suites. Most of its rooms will have at least 50 square feet more floor space than typical private rooms, to allow for easier movement of patients with orthopedic appliances, and to provide adequate space to begin in-room rehabilitation immediately after surgery. The patient's family will also have more space and better sleep-in furniture. The unit will have its own rehabilitation gym, with such features as a training car/vehicle, a handicapped bathroom, and exercise mats--which do not exist at present in the Tower's limited rehabilitation space on the 6th floor.

The result of these changes will be a state-of-the-art Center of Excellence for the CMC Joint Replacement Program. The provision of all intake, preparation, surgical, recovery, and post-operative care at one integrated location will improve the efficiency and cost-effectiveness of the Joint Replacement Program and will optimize patient care and physician productivity. Providing all phases of joint replacement patients' care in areas separated from the general patient population minimizes risks of coming in contact with infectious patients.

B. Addition of New Floors for Future Expansion Space

As stated above, constructing the Joint Replacement Center Staging Area on the 8th floor will displace 36 existing licensed general medical-surgical beds from that floor. To replace them, the project will add a new 9th floor to the Tower, containing 36 private general medical-surgical beds. Above the new 9th floor will be a mechanical powerhouse, and the helipad and patient entrance that must be relocated from the roof of the 8th floor.

C. Renovation and Remodeling of the CMC Emergency Department

The CMC Emergency Department ("ED") is located on the north side of the ground floor of the main hospital building. It sees significant numbers of patients currently, and its visits are expected to increase over the next several years. Two years ago, when its levels of visits per room became extremely high for an ED of only 14 treatment rooms, the ED expanded into an adjoining vacant space formerly used for cardiac catheterizations. That space, which now contains 14 additional treatment spaces, is used daily as an overflow area when the original 14-station ED reaches its workflow capacity. However, this expanded 28-station floor plan does not provide for optimal workflow or efficiency, and does not contain all the care areas and support spaces that are optimal.

In this project, CMC proposes to completely remodel both the original ED and the overflow area into one integrated, highly efficient ED with 24 treatment rooms. The ED's total treatment room capacity will decrease slightly; but its total floor space will increase and its operational efficiency will be markedly improved. The remodeled Department will offer separate drives and canopied entrances for ambulance and walk-in patients, and an integrated "racetrack" floor plan with four nursing stations supervising 24 treatment rooms. All treatment rooms will be enclosed with walls for privacy, rather than with the curtains many now have. The rooms for psychiatric patients will be updated with new surfaces, doors, hardware and equipment designed to ensure patient safety. Another pediatric treatment room will be added. Storage will be increased. A closed medication room will be added. A larger decontamination/shower room will be built, with an exterior entrance. The modernized Department will have a dedicated CT scanner and scanner room; updated diagnostic radiology equipment; an EMS room and decontamination shower; a variety of multi-use and specialized treatment stations/rooms (See Table Five below) and the customary staff support spaces.

D. Miscellaneous Other Construction in the Project

With the addition of patient care spaces and new floors, improvements will be made in the elevators and in the mechanical, plumbing, and electrical systems of the hospital. Various other work will be required to conform to codes that will apply to a taller structure. For example, in the parking garage that connects to the hospital, the

project requires a new electrical room, a new generator and fuel tank, and a new fire command center. A new powerhouse will be installed between the garage and the adjoining "356" building. The HVAC penthouse and the helipad now on the roof of the 8th floor will be moved to the roof of the new 9th floor. An existing bank of eight public elevators serving all 8 floors of the hospital and Tower will be extended to the new top floor. Although a small number of parking spaces on the entire campus will be displaced, CMC will retain a complement of 3,366 parking spaces, which is 1,185 spaces above code requirements.

E. Tables Summarizing the Project's Construction, Cost, Space, and Bed Data

Table Two: Summary of New Construction and Renovation	
	Square Feet
Area of New Construction	84,123 SF
Area of Build-out or Renovation	89,318 SF
Total New & Renovated Construction	173,441 SF

Table Three: Average Construction Costs of Project			
	New Construction	**Renovation**	**Total Project**
Square Feet	84,123 SF	89,318 SF	173,441 SF
Construction Cost	$30,185,044	$21,614,956	$51,800,000
Constr. Cost PSF	$358.82 (rounded)	$242.00	$298.66 PSF

Table Four: Summary of Space Program By Major Area			
Major Area of Project	**New Construction**	**Renovation**	**Total Construction**
Motor Lobby & Elevators From Ground Floor to Eighth Floor	3,828 SF	19,944 SF	23,772 SF
Emergency Department First Floor	2,100 SF	18,129 SF	20,229 SF
Joint Replacement Center of Excellence 7th and 8th Floors	78,195 SF	51,245 SF	129,440 SF
Total Project	84,123 SF	89,318 SF	173,441 SF

Table Five: Proposed Changes in Beds and Floor Space					
	Licensed Medical-Surgical Beds		Patient Floor Space*		
Floor	Current	Proposed	Current SF	Change in SF	Proposed Final SF
First Floor	0	0	123,292 SF	0	123,292 SF
Seventh	33	62 (+29)	47,225 SF	0	47,225 SF
Eighth	36	0 (- 36)	26,500 SF	25,271 SF	51,771 SF
Ninth	0	36 (+36)	0	26,500 SF	26,500 SF

Note: Proposed SF in Table Five are to illustrate changes in patient care floor space in this project. They will not total to the full SF data in Tables Two-Four, which include SF for mechanical/plumbing/electrical work, new elevators, the ED canopy, and tie-in construction not resulting in floor space.

Table Six: Proposed Changes in the Emergency Department			
	Currently	Proposed	Change
Square Feet of the Department	12,870 SF	18,130 SF	5,260 SF
Exam/Treatment Rooms*			
Multipurpose	21	12	-9
Trauma/Critical/Emergent	4	4	No Change
Psychiatric	(in multipurpose)	4	+4
Pediatric	3	4	+1
Total Exam/Treatment Rooms	28	24	-4
Triage Stations	1	1	No Change
Isolation Rooms (in exam room count)	2	2	No Change
Decontamination Rooms/Stations	1	1	No Change
Entrance Drives	1	2	+1

** Most treatment rooms are used interchangeably in peak periods of activity except for trauma and pediatric rooms.*

Table Seven: CMC Existing and Proposed Operating Room Inventory–Specialty Usage, Size, Location

O.R. No.	Current Specialty Usage	Current SF in Size	Current Building	Current Floor	O.R. No.	Proposed Specialty Usage	Proposed SF in Size	Proposed Building	Proposed Floor
1	neuro-spine	663	CMC Tower (Main Building)	Second					
2	neuro-spine	676	CMC Tower (Main Building)	Second					
3	neuro-spine	686	CMC Tower (Main Building)	Second					
4	neuro-spine	457	CMC Tower (Main Building)	Second					
5	neuro-spine	554	CMC Tower (Main Building)	Second					
6	neuro-spine	456	CMC Tower (Main Building)	Second					
7	multi-specialty	422	CMC Tower (Main Building)	Second					
8	multi-specialty	424	CMC Tower (Main Building)	Second					
9	multi-specialty	430	CMC Tower (Main Building)	Second		NO CHANGES PROPOSED TO EXISTING OPERATING ROOMS OR USAGE OTHER THAN			
10	multi-specialty	487	CMC Tower (Main Building)	Second		RELOCATING ALL JOINT REPLACEMENT CASES TO THE			
11	multi-specialty	425	CMC Tower (Main Building)	Second		NEW JOINT REPLACEMENT CENTER OPERATING ROOMS ON THE 8TH FLOOR			
12	multi-specialty	424	CMC Tower (Main Building)	Second					
13	multi-specialty	346	CMC Tower (Main Building)	Second					
14	multi-specialty	393	CMC Tower (Main Building)	Second					
15	multi-specialty	388	CMC Tower (Main Building)	Second					
16	orthopedic	467	CMC Tower (Main Building)	Second					
17	orthopedic	474	CMC Tower (Main Building)	Second					
1	Cardiovascular	642	CMC Tower (Main Building)	Third					
2	Cardiovascular	649	CMC Tower (Main Building)	Third					
3	Cardiovascular	675	CMC Tower (Main Building)	Third					
4	Vascular	620	CMC Tower (Main Building)	Third					
5	Hybrid Cases--Cardiovascular	766	CMC Tower (Main Building)	Third					
6	*Shell O.R.*	*785*	*CMC Tower (Main Building)*	*Third*					
	Average Orthpedic OR SF	***471***							
	Average Tower OR SF	***535***							
1	Oncology	571	Sarah Cannon Cancer Center	First					
2	Oncology	548	Sarah Cannon Cancer Center	First					
3	Oncology	548	Sarah Cannon Cancer Center	First					
4	Oncology	603	Sarah Cannon Cancer Center	First					
1	OB/Gyn and Pediatric	461	Women & Childrens	Second					
2	OB/Gyn and Pediatric	436	Women & Childrens	Second					
3	OB/Gyn and Pediatric	305	Women & Childrens	Second					
4	OB/Gyn and Pediatric	295	Women & Childrens	Second					
5	OB/Gyn and Pediatric	255	Women & Childrens	Second					
6	OB/Gyn and Pediatric	300	Women & Childrens	Second					
7	OB/Gyn and Pediatric	322	Women & Childrens	Second					
8	OB/Gyn and Pediatric	345	Women & Childrens	Second					
9	OB/Gyn and Pediatric	373	Women & Childrens	Second					
10	OB/Gyn and Pediatric	327	Women & Childrens	Second					
11	OB/Gyn and Pediatric	294	Women & Childrens	Second					
12	OB/Gyn and Pediatric	303	Women & Childrens	Second					
13	OB/Gyn and Pediatric	488	Women & Childrens	Second					
1	Plastics and Other Amb Surgeries		Atrium OP ASTC	Fourth/Atrium					
2	Plastics and Other Amb Surgeries		Atrium OP ASTC	Fourth/Atrium					
3	Plastics and Other Amb Surgeries		Atrium OP ASTC	Fourth/Atrium					
4	Plastics and Other Amb Surgeries		Atrium OP ASTC	Fourth/Atrium					
					1	Joint Replacement	625	CMC Tower (Main Building)	Eight
					2	Joint Replacement	625	CMC Tower (Main Building)	Eight
					3	Joint Replacement	625	CMC Tower (Main Building)	Eight
					4	Joint Replacement	625	CMC Tower (Main Building)	Eight
					5	Joint Replacement	625	CMC Tower (Main Building)	Eight
					6	Joint Replacement	625	CMC Tower (Main Building)	Eight
					7	Joint Replacement	625	CMC Tower (Main Building)	Eight
					8	Joint Replacement	625	CMC Tower (Main Building)	Eight
					9	Joint Replacement	625	CMC Tower (Main Building)	Eight
					10	Joint Replacement	625	CMC Tower (Main Building)	Eight
TOTAL EXISTING OPERATING ROOMS = 43 + 1 shelled CV O.R.					*TOTAL PROPOSED OPERATING ROOMS = 54*				

II. Project's Operational Schedule

If CON approval is granted in the Autumn of CY2014, Centennial Medical Center intends to have all operational areas of the project completed by January 1, 2016; so the first full year of operation for purposes of projections in this application is CY2016. All areas of the project will operate 24 hours daily throughout the year.

III. Costs and Funding

The total project cost is estimated at $96,192,007. This will be funded entirely by HCA, Inc., the ultimate parent company of TriStar Centennial Medical Center. The funding will be accomplished by a cash transfer from the parent organization to TriStar Health System, HCA's regional office.

IV. Ownership

TriStar Centennial Medical Center is owned and operated by HCA Health Services of Tennessee, Inc., which is wholly owned through entities that are wholly owned by HCA Holdings, Inc., a national hospital company based in Nashville. Attachment A.4 contains an organization chart of the applicant's chain of ownership up to the parent company.

APPLICANTS WITH HOSPITAL PROJECTS (CONSTRUCTION COST IN EXCESS OF $5 MILLION) AND OTHER FACILITY PROJECTS (CONSTRUCTION COST IN EXCESS OF $2 MILLION) SHOULD COMPLETE THE SQUARE FOOTAGE AND COSTS PER SQUARE FOOTAGE CHART.

UTILIZING THE ATTACHED CHART, APPLICANTS WITH HOSPITAL PROJECTS SHOULD COMPLETE PARTS A-E BY IDENTIFYING, AS APPLICABLE, NURSING UNITS, ANCILLARY AREAS, AND SUPPORT AREAS AFFECTED BY THIS PROJECT. PROVIDE THE LOCATION OF THE UNIT/SERVICE WITHIN THE EXISTING FACILITY ALONG WITH CURRENT SQUARE FOOTAGE, WHERE, IF ANY, THE UNIT/SERVICE WILL RELOCATE TEMPORARILY DURING CONSTRUCTION AND RENOVATION, AND THEN THE LOCATION OF THE UNIT/SERVICE WITH PROPOSED SQUARE FOOTAGE. THE TOTAL COST PER SQUARE FOOT SHOULD PROVIDE A BREAKOUT BETWEEN NEW CONSTRUCTION AND RENOVATION COST PER SQUARE FOOT. OTHER FACILITY PROJECTS NEED ONLY COMPLETE PARTS B-E.

See Attachment B.II.A.

PLEASE ALSO DISCUSS AND JUSTIFY THE COST PER SQUARE FOOT FOR THIS PROJECT.

Table Three (Repeated): Average Construction Costs of Project			
	New Construction	**Renovation**	**Total Project**
Square Feet	84,123 SF	89,318 SF	173,441 SF
Construction Cost	$30,185,044	$21,614,956	$51,800,000
Constr. Cost PSF	$358.82 (rounded)	$242.00	$298.66 PSF

The estimated $51,800,000 construction cost of the project is approximately $298.66 per SF. The 2011-13 hospital construction projects approved by the HSDA had the following costs per SF. This project's construction cost is above the third quartile average of $274.63 per SF. It is relatively more expensive because of the need to stage the renovation and construction in phases in all the areas (emergency room; medical-surgical units) where patient care is being provided continuously.

Table Eight: Hospital Construction Cost Per Square Foot Applications Approved by the HSDA Years: 2011 – 2013			
	Renovation	**New Construction**	**Total Construction**
1st Quartile	$107.15/sq ft	$235.00/sq ft	$151.66/sq ft
Median	$179.00/sq ft	$274.63/sq ft	$227.88/sq ft
3rd Quartile	$249.00/sq ft	$324.00/sq ft	$274.63/sq ft

Source: Health Services and Development Agency website July 2014.

IF THE PROJECT INVOLVES NONE OF THE ABOVE, DESCRIBE THE DEVELOPMENT OF THE PROPOSAL.

Not applicable.

B.II.B. IDENTIFY THE NUMBER AND TYPE OF BEDS INCREASED, DECREASED, CONVERTED, RELOCATED, DESIGNATED, AND/OR REDISTRIBUTED BY THIS APPLICATION. DESCRIBE THE REASONS FOR CHANGE IN BED ALLOCATIONS AND DESCRIBE THE IMPACT THE BED CHANGE WILL HAVE ON EXISTING SERVICES.

Table Nine-A below shows the bed changes proposed in this project. Twenty-nine (29) licensed, private, Joint Replacement medical-surgical beds are to be added to the Tower on its 7th floor, increasing the CMC license from 657 to 686 total beds. Table Nine-B below shows the floors where the changes will occur. Table Nine-C on the following page shows the current numbers and types of licensed beds by floor in all CMC buildings.

Table Nine-A: Proposed Changes in Assignment of Licensed Hospital Beds

Bed Assignment	Current Assignment	Proposed Assignment
Medical-Surgical	281	310 (+29)
Adult Critical Care	88	88 (no change)
Neonatal Intensive Care	60	60 (no change)
Obstetrics/Gyn	75	75 (no change)
Pediatric	21	21 (no change)
Psychiatric	132	132 (no change)
Rehabilitation	0	0 (no change)
Total Licensed Complement	657	686 (+29)

Source: Hospital management.

Table Nine-B: Proposed Changes in Licensed Beds By Floor

Tower Floor	Licensed Beds	
	Current	Proposed
Seventh	33	62 (+29)
Eighth	36	0 (- 36)
New Ninth	0	36 (+36)
Roof (helipad / powerhouse)	0	0
Total Project	69	98 (+29)

Table Nine-C: TriStar Centennial Medical Center--Current Licensed Beds By Type and Location								
	Floor	Medical-Surgical	Intensive Care	OB/Gyn	NICU	Pediatric	Pyschiatric	Floor Totals
Women's and Children's	8			9	20			29
	7				40			40
	6			25				25
	5							0
	4			25				25
	3			16		11		27
	Subtotal		*0*	*75*	*60*	*11*	*0*	146
Tower	8	36						36
	7	33						33
	6	54	8					62
	5	33	32					65
	4	33	32					65
	3		16					16
	2					10		10
	Subtotal	*189*	*88*		*0*	*10*	*0*	287
Parthenon Pavillion	4						33	33
	3						39	39
	2						24	24
	1						36	36
	Subtotal	*0*	*0*		*0*	*0*	*132*	132
Sarah Cannon	4	27						27
	3	44						44
	2	21						21
	Subtotal	*92*	*0*		*0*	*0*	*0*	92
	Total	281	88	75	60	21	132	657

B.II.C. AS THE APPLICANT, DESCRIBE YOUR NEED TO PROVIDE THE FOLLOWING HEALTH CARE SERVICES (IF APPLICABLE TO THIS APPLICATION):

1. **ADULT PSYCHIATRIC SERVICES**
2. **ALCOHOL AND DRUG TREATMENT ADOLESCENTS >28 DAYS**
3. **BIRTHING CENTER**
4. **BURN UNITS**
5. **CARDIAC CATHETERIZATION SERVICES**
6. **CHILD AND ADOLESCENT PSYCHIATRIC SERVICES**
7. **EXTRACORPOREAL LITHOTRIPSY**
8. **HOME HEALTH SERVICES**
9. **HOSPICE SERVICES**
10. **RESIDENTIAL HOSPICE**
11. **ICF/MR SERVICES**
12. **LONG TERM CARE SERVICES**
13. **MAGNETIC RESONANCE IMAGING (MRI)**
14. **MENTAL HEALTH RESIDENTIAL TREATMENT**
15. **NEONATAL INTENSIVE CARE UNIT**
16. **NON-RESIDENTIAL METHADONE TREATMENT CENTERS**
17. **OPEN HEART SURGERY**
18. **POSITIVE EMISSION TOMOGRAPHY**
19. **RADIATION THERAPY/LINEAR ACCELERATOR**
20. **REHABILITATION SERVICES**
21. **SWING BEDS**

I. The Need for Emergency Room Renovation

A. Historic and Projected Utilization

TriStar Centennial Medical Center ("CMC") has three Emergency Department ("ED") locations. Its main ED is on the ground floor of the 8-story Main Tower, built almost twenty years ago in 1994-95. A smaller ED exclusively for obstetrics emergencies is in the Women's and Children's Hospital facility in another section of the CMC campus. There is a satellite CMC ED in Spring Hill, south of Davidson County. Being under one license, all three of these ED's visit volumes are reported as a consolidated number in the Joint Annual Reports.

This project, however, concerns only the Main Tower ED, the principal Emergency Care resource and entry point for the complex. As of 2012, it had only 14 treatment rooms and was too heavily utilized to avoid long patient wait times. In that

year, it was expanded to take in an adjoining vacant space (formerly a cardiac catheterization area) that provided "overflow" space for 14 more stations, giving it the 28 stations it has today.

In 2013, the main ED had 34,408 visits, as shown in Table Eleven below. This was an average of 2,458 visits per treatment station for the original 14-station ED. HCA's own planning standard calls for ED treatment rooms to average 1800-2,200 visits per room. Including the "overflow" area with another 14 stations, it was an average of 1,229 visits per station. The operational reality is that the 14-station original ED remains overloaded at peak times; and even with the additional 14-station overflow area, peak times can be challenging due to the layout of the space.

As Table Ten-A indicates, for the last four full calendar years 2011 through 2013, Tower ED visits have increased steadily at a compound annual growth rate ("CAGR") of more than 8%. Even if future Tower ED visits are projected at a very conservative 5% CAGR, by CY2017 the Tower ED will have 42,746 visits. With the 24 stations proposed in this project, the ED's average visits per room in CY2017 are conservatively projected to be 1,781 visits per treatment room (42,746 / 24). Peak visit times, of course, will be much more intense than in low visit times of day, as they are in all ED's.

Table Ten-A: Annual Visits to the Tower ED

Year	Annual Visits		Annual Change, Tower ED Visits
	Tower ED	All CMC ED's	
Historical			
2010	27,350	32,101	--
2011	27,482	34,534	+0.5%
2012	31,124	38,774	+13.3%
2013	35,168	48,146	+13.0%
2010-2013 Total Change			*+28.6%*
2010-2013 CAGR			*> 8% CAGR*
Projected (at 5% CAGR)			
2014	36,926		+5%
2015	38,772		+5%
Project Year 1 - 2016	40,711		+5%
Project Year 2 - 2017	42,746		+5%

Source: Tower ED visits from CMC Management; total CMC visits from JAR.

B. Proposed Capacity is Appropriate

CMC's proposed ED capacity is conservative but appropriate. Several years ago, the American College of Emergency Physicians (ACEP) published a planning guide for hospital emergency departments. As shown in Table Ten-B below, at 24 treatment rooms, the CMC ED improvement project will be reasonably consistent with the conservative end of the range of rooms ACEP recommended.

In addition, the applicant's parent company, which designs and builds hundreds of hospital operating rooms nationally, uses a planning guideline of 1,800-2,200 visits per treatment room for most communities and facilities. The Tower ED's projected visits in 2017 will be approximately 1,743 visits per room. So its proposed capacity of 24 treatment rooms should be able to efficiently serve significantly increased visits beyond CY2017 before further expansion is needed.

Table Ten-B: Treatment Room (Station) Recommendations
American College of Emergency Physicians

Annual Visits	Rooms, Low Range	Rooms, High Range	Proposed by CMC, 2017
30,000	20	26	
40,000	25	33	24 rooms for 41,823 visits
50,000	30	40	
60,000	35	47	

Source: Emergency Department Design--A Practical Guide to Planning for the Future, American College of Emergency Physicians.

C. Operational Issues in the Tower ED Must Be Addressed

Apart from capacity considerations, the Tower ED has several operational issues that will require extensive renovation. One is the lack of a CT scanner within the department. Having to transport patients many times a day to the Imaging Department in another part of the hospital ties up staff and delays the diagnostic process. Often the nurses have to take a patient to CT immediately after the patient's arrival--for example, apparent stroke victims. In such cases the nursing staff must remain with the patient in

Imaging to accomplish related tasks that would normally be done more quickly in the ED itself.

Another issue is patient privacy; 11 of the 28 ED treatment stations (39%) are only curtained bays with no hard walls on one or more sides to ensure appropriate privacy for patients and family.

Room sizes vary, with some more able to accommodate staff and visitors than others. The ED has no private family counseling room where critical information can be conveyed and care decisions made in complete privacy and confidentiality.

Treatment rooms used for behavioral/psychiatric patients need to be modified with newer surfaces, hardware, fixtures, doors, and furnishings to enhance patient safety.

Arriving ambulances must currently drive in, and then back up to deliver their patients; this is vexing to EMS personnel. In addition, the decontamination shower in the ED at present is tiny and has no external access to avoid walking through the ED itself. Medications storage is inadequate and there is no closed medications room.

All of these issues will be resolved in the proposed renovation. A dedicated CT scanning room will be provided, and existing radiological equipment will be updated. All treatment rooms will be of uniform size, and all will be hard-walled and private. Four "safe" psychiatric examination/treatment rooms will be provided, constructed with all appropriate safety features to protect the patients from harming themselves and others. Two ED entrance drives will be created, separating patients who arrive by ambulance from patients arriving by private vehicle. Ambulances will be able to drive directly up to deliver their stretcher patients, without competing with private vehicles and without having to back up into the entrance. A second medication area will be added in the form of a "closed" (securable) room.

II. Need for the Joint Replacement Center and Its Dedicated 29-bed Inpatient Unit

Centennial's orthopedic physicians perform a large and growing volume of joint replacement cases. In 2013, they performed approximately 1,150 such cases. Their caseloads of that type have increased an average of 9% annually during the past two years.

In early 2014, an event occurred that will more than double Centennial's joint replacement caseloads next year. The Southern Joint Replacement Institute ("SJRI"), a Nashville physician group of four orthopedists specializing in joint replacement cases, determined to relocate its offices and its cases to the Centennial campus--and to recruit a fifth experienced specialist to the group by January of 2015.

The SJRI physicians are widely recognized for their quality of care and their contributions to their areas of surgical practice. They are internationally recognized lecturers and authors in the field of joint replacement. They hold national and international patents for implant component designs, and consult with major orthopedic implant manufacturers. They are actively involved in clinical research and will continue and extend that work at Centennial, in cooperation with the Sarah Cannon Research Institute. They offer a partnership, clinically based fellowship program for future joint replacement surgeons.

The expertise and case volumes coming to Centennial in CY2015 will more than double the Joint Replacement program's volumes as well as ensure its rapid future growth, as the population ages and joint "renewal" becomes increasingly in demand. The proposed project responds to this opportunity to enlarge service to the region and to the profession, by creating a state-of-the-art Center of Excellence for performing this type of surgery, and for centrally integrating, managing, and improving the care processes associated with it. By means of express elevators and a dedicated reception, waiting, and staging area, the project will provide arriving patients with a largely self-contained physical environment, free of movement through areas of the hospital that serve infectious patients. It will have a suite of operating rooms that are much larger than standard rooms, to provide circulating space for six-person teams to move easily around an oversized operating table with all the equipment and supplies needed to accomplish

such complex surgery efficiently and effectively. The block scheduling of two rooms for six-person surgical teams will enhance the medical staff's productivity. Post-surgical care is immediately available in a dedicated recovery area. On the floor below, patients will be served in a dedicated 29-bed Joint Replacement medical-surgical nursing unit with the capability of initiating rehabilitation immediately after surgery.

It is not possible to achieve an integrated Center of Excellence like this at any other location on campus. As shown in Table Seven in an earlier section of the application, Centennial now has 43 operating rooms (44 with a shelled vascular room that will soon open). Those operating rooms are distributed among five separate buildings or locations--four of which are dedicated to heart/vascular, oncology, outpatient surgery, and women's and children's cases not involving joint replacements. All joint replacement cases currently take place in Tower operating rooms that are undersized by current orthopedic standards, and are not adjacent to any area that can be converted to the integrated intake, staging, recovery, and inpatient care phases of the continuum of care that distinguish a Center of Excellence in this specialty.

Table Ten-C on the second following page shows the data supporting the construction of this new surgical capacity and specialized orthopedic bed capacity on Centennial's 7th and 8th Tower floors.

While in its early years, the Center's O.R. suite may be used for some orthopedic cases other than Joint Replacement cases. But Table Eleven focuses only on the proposed Joint Replacement Program. The surgeons who will use the facility are divided into two groups, so that the significance of the SJRI group to case volumes in CY2015 can be appreciated. The case volumes at Centennial will increase from 1,196 this year to 2,744 in CY2015. In the CY2015 transition year, they will be performed in the existing Tower operating rooms. By CY2016, the Center will be open and these cases will move to the 8th floor of the Tower. Although both the SJRI group and other practice's cases have been increasing at 8% to 9% annually, Table Eleven conservatively projects the SJRI cases to increase 5% annually and other surgeons' cases to increase 3% annually.

At current times for case performance and room turnaround (cleaning and preparation for the next case) that will give the operating rooms a theoretical annual

average utilization of 54.1% of available minutes, in Year Four. However, reality is very different. Joint Replacement cases are scheduled heavily into the first three days of the week, and relatively lightly after that. One reason is to get the patient to an inpatient room and starting rehabilitation immediately, before rehabilitation staff (like all hospital staff) decreases on the weekends. A second reason is that it allows patients being discharged to other facilities (e.g. rehabilitation hospitals) to complete admissions requirements during the week when those facilities and the patients' insurers are available to do the paperwork. Late-week surgery defeats both goals and leads to excessively long patient stays over weekends. So the ten O.R.'s in the Center will be scheduled for Joint Replacement cases at 90% to 100% of capacity in the first three days of the week. This peak level of activity reflects the appropriate management of the continuum of care that has evolved for this type of patient.

The lower part of Table Ten-C illustrates the high utilization of the proposed new 29-bed specialty unit on the 7th floor, designed specifically for Joint Replacement patient care. At a 3-day average length of stay ("ALOS") the unit will be highly utilized by Joint Replacement patients from the very first year--increasing from approximately 81% in CY2016 to almost 93% in CY2019.

Table Ten-C: Utilization Projections 2016-2020, Joint Replacement Center of Excellence Operating Suite and Inpatient Unit							
Calendar Year:	**2013**	**2014**	**2015**	**Year 1 2016**	**Year 2 2017**	**Year 3 2018**	**Year 4 2019**
SJRI Joint Replacement Cases at Centennial (Note 1)	0	0	1,500	1,575	1,654	1,736	1,823
Other Centennial Surgeons' Joint Replacement Cases (Note 2)	1,150	1,196	1,244	1,294	1,345	1,399	1,455
Total Joint Replacement Cases Performed in the Center	1,150	1,196	2,744	2,869	2,999	3,136	3,278
10 O.R. Orthopedic Operating Suite, Joint Replacement Center, 8th Floor							
Annual Cases Per O.R.				287	300	314	328
Minutes per Case (168 Case Min. + 30 min. Room Turnaround)				198	198	198	198
Total O.R. Minutes Including Room Turnaround				567,982	593,819	620,846	649,118
Minutes of O.R. Capacity, 10 O.R.'s, 250 days/yr (Note 3)				1,200,000	1,200,000	1,200,000	1,200,000
Average O.R. Suite Utilization Rate for Joint Replacement Cases Mon-Fri				47.3%	49.5%	51.7%	54.1%
Average O.R. Suite Utilization for Joint Replacement Cases Mon-Wed (Note 4)				>90%	>90%	>90%	>90%
Joint Replacement Inpatient Unit--29 Beds, 7th Floor							
Patient days @ 3.0 day ALOS				8,606	8,997	9,407	9,835
Average Daily Census, 7-day week				23.6	24.7	25.8	26.9
Average Annual Occupancy Rate				81.3%	85.0%	88.9%	92.9%

Source: Hospital management.

Notes:

1. Four SJRI surgeons relocating to Centennial by Jan 2015 project retention of 1,500 cases in 2015; addition of 5th surgeon Jan 2015, and 5% CAGR of cases to 2019.

2. Current Centennial surgeons have seen average annual 9.04% increase in joint replacement cases; CMC projects this to continue at a minimum of 4%.

3. 250 days (Mon-Fri, 50 weeks) X 8 hrs per day X 60 minutes per hour X 10 O.R.'s.

4. Joint replacement patients are "front-loaded" Mon-Wed in the weekly O.R. schedule to optimize access to rehab on weekdays when rehab staff are most available.

Centennial's entire medical-surgical bed complement--not just this proposed 29-bed unit--is highly utilized and needs additional capacity. Tables Ten-D(1) and (2) below (taken from data in Table Sixteen-D in Section C.I.6 of the application), provide historic (2011-2013) and projected (2014-2017) utilization for just medical-surgical bed utilization. The first includes all bed days--days of formally admitted patients, and also days of "observation" patients. Average daily census, and average annual occupancy, are based on those actual days. The hospital's medical-surgical beds--with the proposed 29-bed unit in service--will have an average annual occupancy of 91.7% in CY2016, and 96.5% in CY2017. With occupancies like this, the Joint Replacement Center of Excellence project cannot be carried out without the proposed licensed bed increase in medical-surgical capacity.

Table Ten-D (1): Historic and Projected Medical-Surgical Bed Utilization
TriStar Centennial Medical Center
CY2011-CY2017

Year	Med-Surg Beds	Med-Surg Bed Annual Capacity	Bed Days, Including Obs. Days	Avg. Daily Census on Total Days	Total Average Occupancy
Historic					
CY2011	258	94,170	69,558	190.6	73.9%
CY2012	281	102,846	81,423	222.5	79.2%
CY2013	281	102,565	84,959	232.8	82.8%
Projected					
CY2014	281	102,565	89,553	245.4	87.3%
CY2015	281	102,565	98,669	258.0	96.2%
Yr 1 CY2016	310	113,460	103,774	284.3	91.7%
Yr 2 CY2017	310	113,150	109,149	299.0	96.5%

Table Ten-D(2): Historic and Projected Medical-Surgical Bed Utilization
TriStar Centennial Medical Center
CY2011-CY2017

Year	Med-Surg Beds	Med-Surg Bed Annual Capacity	Disch. Days Excluding Obs. Days	Avg. Daily Census on Disch. Days	Total Average Occupancy
Historic					
CY2011	258	94,170	63,894	175.1	67.8%
CY2012	281	102,846	67,887	185.5	66.0%
CY2013	281	102,565	72,415	198.4	70.6%
Projected					
CY2014	281	102,565	75,226	206.1	73.3%
CY2015	281	102,565	83,849	229.7	81.8%
Yr 1 CY2016	310	113,460	88,844	242.3	78.2%
Yr 2 CY2017	310	113,150	93,291	255.6	82.4%

Source: Table Sixteen-C. CY2012 and CY2016 are 366-day leap years.

B.II.D. DESCRIBE THE NEED TO CHANGE LOCATION OR REPLACE AN EXISTING FACILITY.

Not applicable.

B.II.E. DESCRIBE THE ACQUISITION OF ANY ITEM OF MAJOR MEDICAL EQUIPMENT (AS DEFINED BY THE AGENCY RULES AND THE STATUTE) WHICH EXCEEDS A COST OF $1.5 MILLION; AND/OR IS A MAGNETIC RESONANCE IMAGING SCANNER (MRI), POSITRON EMISSION TOMOGRAPHY (PET) SCANNER, EXTRACORPOREAL LITHOTRIPTER AND/OR LINEAR ACCELERATOR BY RESPONDING TO THE FOLLOWING:

1. For fixed site major medical equipment (not replacing existing equipment):

- **a. Describe the new equipment, including:**
  1. **Total Cost (As defined by Agency Rule);**
  2. **Expected Useful Life;**
  3. **List of clinical applications to be provided; and**
  4. **Documentation of FDA approval.**
- **b. Provide current and proposed schedule of operations.**

2. For mobile major medical equipment:

- **a. List all sites that will be served;**
- **b. Provide current and/or proposed schedule of operations;**
- **c. Provide the lease or contract cost;**
- **d. Provide the fair market value of the equipment; and**
- **e. List the owner for the equipment.**

3. Indicate applicant's legal interest in equipment (e.g., purchase, lease, etc.) In the case of equipment purchase, include a quote and/or proposal from an equipment vendor, or in the case of an equipment lease provide a draft lease or contract that at least includes the term of the lease and the anticipated lease payments.

Not applicable. The project does not include major medical equipment as defined by HSDA's statute and regulations ($2 million or more capital cost; or a listed service in HSDA regulation). A CT scanner will be added to the Emergency Department; but its cost including taxes and delivery, and including five years of maintenance contract expense, will not exceed $1.4 million.

B.III.A. ATTACH A COPY OF THE PLOT PLAN OF THE SITE ON AN 8-1/2" X 11" SHEET OF WHITE PAPER WHICH MUST INCLUDE:

1. **SIZE OF SITE (IN ACRES);**
2. **LOCATION OF STRUCTURE ON THE SITE;**
3. **LOCATION OF THE PROPOSED CONSTRUCTION; AND**
4. **NAMES OF STREETS, ROADS OR HIGHWAYS THAT CROSS OR BORDER THE SITE.**

PLEASE NOTE THAT THE DRAWINGS DO NOT NEED TO BE DRAWN TO SCALE. PLOT PLANS ARE REQUIRED FOR ALL PROJECTS.

See Attachment B.III.A for the plot plan.

B.III.B.1. DESCRIBE THE RELATIONSHIP OF THE SITE TO PUBLIC TRANSPORTATION ROUTES, IF ANY, AND TO ANY HIGHWAY OR MAJOR ROAD DEVELOPMENTS IN THE AREA. DESCRIBE THE ACCESSIBILITY OF THE PROPOSED SITE TO PATIENTS/CLIENTS.

TriStar Centennial Medical Center is a tertiary acute care facility well known to the residents of its eight-county primary service area. It is highly accessible, located in central Nashville/Davidson County, within minutes of the I-240 loop that circles Nashville and connects to numerous Interstate, U.S., and Tennessee highways running radially in all directions through the seven adjoining counties. The Centennial campus is on municipal bus lines and is convenient by automobile to major Nashville thoroughfares such as Broadway/West End Avenue, Charlotte Avenue, and Interstates 40, 65, 24, 240, and 440.

Tables Eleven-A and Eleven-B below provide average driving distances and driving times between TriStar Centennial Medical Center and the communities and acute care providers across Centennial's eight-county service area.

Table Eleven-A: Mileage and Drive Times Between Project and Major Communities in the Primary Service Area			
Community	**County**	**Distance in Miles**	**Drive Time in Minutes**
Clarksville	Montgomery	49.5	54 min.
Ashland City	Cheatham	21.2	30 min.
Franklin	Williamson	22.3	27 min.
Murfreesboro	Rutherford	35.2	30 min.
Lebanon	Wilson	32.3	36 min.
Gallatin	Sumner	31.1	37 min.
Springfield	Robertson	30.4	39 min.

Source: Google Maps, July 2014

Table Eleven-B: Mileage and Drive Times Between Project and Other General Acute Care Hospitals in the Primary Service Area			
Facility and Address	**County**	**Distance in Miles**	**Drive Time in Minutes**
TriStar Ashland City Medical Center	Cheatham	21.4	31 min.
TriStar Summit Medical Center	Davidson	13.9	19 min.
Metro NV General Hospital	Davidson	1.8	5 min.
Saint Thomas Midtown Hospital (Baptist)	Davidson	0.8	3 min.
Saint Thomas West Hospital	Davidson	2.9	8 min.
Saint Thomas Hospital for Spinal Surgery	Davidson	0.6	3 min.
TriStar Skyline Medical Center, Nashville	Davidson	9.3	16 min.
TriStar Southern Hills Medical Center	Davidson	10.0	17 min.
Vanderbilt Medical Center	Davidson	1.3	5 min.
Gateway Medical Center	Montgomery	46.9	47 min.
Northcrest Medical Center	Robertson	28.0	34 min.
Saint Thomas Rutherford Hospital	Rutherford	32.9	37 min.
TriStar Stonecrest Medical Center	Rutherford	22.8	27 min.
Sumner Regional Medical Center	Sumner	31.9	38 min.
TriStar Hendersonville Medical Center	Sumner	19.5	24 min.
Williamson Medical Center	Williamson	20.0	23 min.
University Medical Center (UMC)	Wilson	32.2	37 min.

Source: Google Maps, July 2014

B.IV. ATTACH A FLOOR PLAN DRAWING FOR THE FACILITY WHICH INCLUDES PATIENT CARE ROOMS (NOTING PRIVATE OR SEMI-PRIVATE), ANCILLARY AREAS, EQUIPMENT AREAS, ETC.

See attachment B.IV.

IV. FOR A HOME CARE ORGANIZATION, IDENTIFY

1. **EXISTING SERVICE AREA (BY COUNTY);**
2. **PROPOSED SERVICE AREA (BY COUNTY);**
3. **A PARENT OR PRIMARY SERVICE PROVIDER;**
4. **EXISTING BRANCHES AND/OR SUB-UNITS; AND**
5. **PROPOSED BRANCHES AND/OR SUBUNITS.**

Not applicable. The application is not for a home care organization.

C(I) NEED

C(I).1. DESCRIBE THE RELATIONSHIP OF THIS PROPOSAL TO THE IMPLEMENTATION OF THE STATE HEALTH PLAN AND TENNESSEE'S HEALTH: GUIDELINES FOR GROWTH.

A. PLEASE PROVIDE A RESPONSE TO EACH CRITERION AND STANDARD IN CON CATEGORIES THAT ARE APPLICABLE TO THE PROPOSED PROJECT. DO NOT PROVIDE RESPONSES TO GENERAL CRITERIA AND STANDARDS (PAGES 6-9) HERE.

B. APPLICATIONS THAT INCLUDE A CHANGE OF SITE FOR A HEALTH CARE INSTITUTION, PROVIDE A RESPONSE TO GENERAL CRITERION AND STANDARDS (4)(a-c).

Project-Specific Review Criteria: Construction, Renovation, Expansion, and Replacement of Health Care Institutions

Project-Specific Review Criteria--Acute Care Bed Services

From an areawide planning standpoint, this project adds only an insignificant number of acute care beds. It increases the service area's licensed acute care beds by only 29 beds. That is a change of only 6/10ths of 1% of the primary service area's total licensed short-term acute care hospital beds, and an increase of only 2% in the areawide bed surplus projected by the planning formula for CY 2018.

1. The following methodology should be used and the need for hospital beds should be projected four years into the future from the current year...(guidelines detail the steps of the bed need projection methodology; see pp. 15-16 of Guidelines for Growth.)

The Tennessee Department of Health's most recently issued bed need projection (for 2014-2018) is provided on the second following page. It indicates a surplus of 1,455 acute care hospital beds in the project's eight-county primary service area. This project would increase the surplus by only 2%. It would make a difference of only 6/10ths of 1% in areawide hospital bed complements.

Table Twelve: Impact of Twenty-Nine Additional Licensed Hospital Beds On Service Area Hospital Bed Complements (TDH Guidelines for Growth Bed Need Formula for 2018)					
PSA County	2012 Licensed Beds	Bed Surplus 2018	Proposed New Beds	% of Licensed Beds	% of Bed Surplus
Cheatham	12	3	0		
Davidson	3,754	940	+29	0.8%	3%
Montgomery	270	105	0		
Robertson	109	44	0		
Rutherford	387	66	0		
Sumner	303	120	0		
Williamson	185	64	0		
Wilson	245	113	0		
PSA	5,265	1,455	+29	0.6%	2%

Source: TN Department of Health Hospital Bed Need Projection, 2014-2018.

2. New hospital beds can be approved in excess of the "need standard for a county" if the following criteria are met:

a) All existing hospitals in the projected service area have an occupancy level greater than or equal to 80% for the most recent JAR. Occupancy should be based on the number of licensed beds rather than on staffed beds.

b) All outstanding new acute care bed CON projects in the proposed service area are licensed.

c) The Health Facilities Agency may give special consideration to acute care bed proposals for specialty health service units in tertiary care regional referral hospitals.

a. Areawide hospital bed occupancy at the area's general hospitals, as reported in their 2013 Joint Annual Reports, averaged below 80%.

b. Vanderbilt Medical Center has had major bed additions approved since 2007, which are not fully implemented. Summit Medical Center has a small bed addition that was approved recently, and is not yet implemented.

c. This exception is merited. TriStar Centennial Medical Center is clearly a tertiary care, regional referral hospital, drawing patients from 92 Tennessee counties and 9 States in CY2013, and offering highly advanced care programs in multiple specialties. This proposed 7th floor 29-bed unit is a specialized nursing unit for CMC's Joint Replacement program. The unit varies from other medical-surgical units in terms of (1) its restricted patient population; (2) its oversize rooms; (3) its patients' separation from infectious patients in other parts of the hospital; and (4) its physical and operational integration with surgery, recovery, and rehabilitation stages of care.

ACUTE-CARE BED NEED PROJECTIONS FOR 2014 AND 2018, BASED ON FINAL 2012 HOSPITAL JARS

COUNTY	2012		CURRENT	SERVICE AREA POPULATION			PROJECTED		PROJECTED		2012 ACTUAL BEDS		SHORTAGE/SURPLUS	
	INPATIENT DAYS	ADC	NEED	2012	2014	2018	ADC-2014	NEED 2014	ADC-2018	NEED 2018	LICENSED	STAFFED	LICENSED	STAFFED
Anderson	47,731	131	164	94,639	95,470	97,048	132	165	134	168	301	255	-133	-87
Beford	7,281	20	30	17,853	18,323	19,505	20	31	22	33	60	60	-27	-27
Benton	1,959	5	11	2,278	2,264	2,243	5	11	5	11	25	12	-14	-1
Bledsoe	2,984	8	15	2,088	2,078	2,085	8	15	8	15	25	25	-10	-10
Blount	51,235	140	176	97,454	99,770	104,941	144	180	151	189	304	238	-115	-49
Bradley	38,232	105	131	82,623	84,112	87,052	107	133	110	138	351	207	-213	-69
Campbell	18,681	51	68	21,557	21,827	22,326	52	69	53	70	120	97	-50	-27
Cannon	6,638	18	28	3,813	3,874	3,969	18	29	19	29	60	50	-31	-21
Carroll	6,718	18	28	14,137	14,118	14,111	18	28	18	28	115	68	-87	-40
Carter	15,622	43	58	29,978	30,095	30,448	43	58	43	59	121	79	-62	-20
Cheatham	1,549	4	9	1,364	1,381	1,413	4	9	4	9	12	12	-3	-3
Chester	.	.	.	.	.	.	.	.	.	.	.	.	.	.
Claiborne	7,878	22	32	12,643	12,753	13,009	22	33	22	33	85	39	-52	-6
Clay	5,592	15	24	5,364	5,343	5,345	15	24	15	24	36	34	-12	-10
Cocke	7,541	21	31	16,066	16,425	17,225	21	32	22	33	74	36	-41	-3
Coffee	31,305	86	107	56,704	57,545	59,957	87	109	91	113	214	159	-101	-46
Crockett	.	.	.	.	.	.	.	.	.	.	.	.	.	.
Cumberland	21,801	60	78	45,561	46,213	48,038	61	79	63	81	189	123	-108	-42
Davidson	763,385	2,092	2,614	1,451,264	1,488,518	1,562,068	2,145	2,681	2,251	2,814	3,754	3,129	-940	-315
Decatur	3,411	9	16	5,011	5,052	5,157	9	17	10	17	40	27	-23	-10
DeKalb	4,110	11	19	7,665	7,707	7,805	11	19	12	19	71	56	-52	-37
Dickson	18,017	49	66	33,604	33,850	34,413	50	66	51	67	157	120	-90	-53
Dyer	12,937	35	49	33,319	33,224	33,183	35	49	35	49	225	120	-176	-71
Fayette	714	2	5	2,325	2,406	2,603	2	5	2	6	46	10	-40	-4
Fentress	0	0	0	.	.	.	.	.	.	.	85	54	.	.
Franklin	22,404	61	80	33,182	33,338	33,983	62	80	63	81	152	110	-71	-29
Gibson	5,069	14	23	7,947	8,051	8,206	14	23	14	23	209	90	-186	-67
Giles	9,124	25	37	12,333	12,327	12,331	25	37	25	37	95	81	-58	-44
Grainger	.	.	.	.	.	.	.	.	.	.	.	.	.	.
Greene	27,601	76	96	50,076	50,565	51,689	76	97	78	99	240	170	-141	-71
Grundy	.	.	.	.	.	.	.	.	.	.	.	.	.	.
Hamblen	39,464	108	135	76,894	77,909	80,095	110	137	113	141	302	212	-161	-71
Hamilton	392,786	1,076	1,345	696,028	710,184	736,123	1,098	1,372	1,138	1,423	1,551	1,235	-128	188
Hancock	1,229	3	8	1,661	1,655	1,652	3	8	3	8	10	10	-2	-2
Hardeman	815	2	6	2,537	2,508	2,480	2	6	2	6	51	23	-45	-17
Hardin	7,103	20	30	14,725	14,795	14,963	20	30	20	30	58	49	-28	-19
Hawkins	3,542	10	17	10,354	10,441	10,555	10	17	10	17	50	46	-33	-29
Haywood	1,617	4	9	3,872	3,831	3,811	4	9	4	9	62	36	-53	-27
Henderson	2,444	7	13	6,143	6,182	6,284	7	13	7	13	45	45	-32	-32
Henry	16,775	46	62	28,422	28,546	28,712	46	62	46	62	142	101	-80	-39
Hickman	492	1	4	1,425	1,427	1,444	1	4	1	4	15	15	-11	-11
Houston	2,870	8	14	4,017	4,052	4,109	8	15	8	15	25	25	-10	-10
Humphreys	1,697	5	10	3,463	3,466	3,477	5	10	5	10	25	25	-15	-15

ACUTE-CARE BED NEED PROJECTIONS FOR 2014 AND 2018, BASED ON FINAL 2012 HOSPITAL JARS

COUNTY	2012		CURRENT	SERVICE AREA POPULATION			PROJECTED		PROJECTED		2012 ACTUAL BEDS		SHORTAGE/SURPLUS	
	INPATIENT DAYS	ADC	NEED	2012	2014	2018	ADC-2014	NEED 2014	ADC-2018	NEED 2018	LICENSED	STAFFED	LICENSED	STAFFED
Jackson	.	.	.	.	.	.	.	.	.	.	.	.	.	.
Jefferson	8,533	23	35	17,351	17,752	18,648	24	35	25	37	58	58	-21	-21
Johnson	51	0	1	233	232	232	0	1	0	1	2	2	-1	-1
Knox	442,861	1,213	1,517	781,145	797,585	831,502	1,239	1,549	1,292	1,614	1,877	1,777	-263	-163
Lake	.	.	.	.	.	.	.	.	.	.	.	.	.	.
Lauderdale	3,044	8	15	4,293	4,252	4,218	8	15	8	15	25	25	-10	-10
Lawrence	9,298	26	37	18,503	18,540	18,545	26	37	26	37	99	80	-62	-43
Lewis	.	.	.	.	.	.	.	.	.	.	.	.	.	.
Lincoln	7,435	20	31	17,852	18,159	18,898	21	31	22	32	59	59	-27	-27
Loudon	6,123	17	26	12,093	12,365	12,912	17	27	18	28	50	30	-22	-2
McMinn	15,973	44	59	32,166	32,503	33,184	44	60	45	61	190	111	-129	-50
McNairy	4,953	14	22	11,089	11,200	11,451	14	22	14	23	45	45	-22	-22
Macon	3,793	10	13	5,934	6,057	6,301	11	18	11	19	25	25	-6	-6
Madison	179,979	493	616	281,828	283,339	286,657	496	620	502	627	787	729	-160	-102
Marion	14,492	40	54	9,647	9,762	9,980	40	55	41	56	70	63	-14	-7
Marshall	675	2	3	1,895	1,911	1,956	2	5	2	5	25	12	-20	-7
Maury	42,096	115	144	102,509	102,974	104,036	116	145	117	146	255	215	-109	-69
Meigs	.	.	.	.	.	.	.	.	.	.	.	.	.	.
Monroe	10,213	28	40	18,562	18,905	19,665	29	41	30	42	59	59	-17	-17
Montgomery	43,692	120	150	126,007	130,796	139,341	124	155	132	165	270	220	-105	-55
Moore	.	.	.	.	.	.	.	.	.	.	.	.	.	.
Morgan	.	.	.	.	.	.	.	.	.	.	.	.	.	.
Obion	10,628	29	42	20,715	20,637	20,560	29	42	29	41	173	85	-132	-44
Overton	16,555	45	61	21,794	22,030	22,558	46	62	47	63	114	82	-51	-19
Perry	6,000	16	26	5,114	5,146	5,192	17	26	17	26	53	25	-27	1
Pickett	.	.	.	.	.	.	.	.	.	.	.	.	.	.
Polk	0	0	0	.	.	.	.	.	.	.	25	25	.	.
Putnam	61,949	170	212	105,866	108,424	113,926	174	217	183	228	247	243	-19	-15
Rhea	3,533	10	17	7,701	7,893	8,211	10	17	10	18	25	25	-7	-7
Roane	6,593	18	28	13,068	13,113	13,243	18	28	18	28	105	36	-77	-8
Robertson	16,379	45	61	28,555	29,416	31,016	46	62	49	65	109	66	-44	-1
Rutherford	80,182	220	275	229,262	241,520	267,897	231	289	257	321	387	369	-66	-48
Scott	.	.	.	.	.	.	.	.	.	.	.	.	.	.
Sequatchie	.	.	.	.	.	.	.	.	.	.	.	.	.	.
Sevier	13,019	36	50	37,258	38,189	40,405	37	51	39	53	79	69	-26	-16
Shelby	934,049	2,559	3,199	1,416,974	1,430,639	1,457,026	2,584	3,230	2,631	3,289	4,177	3,115	-888	174
Smith	10,604	29	42	13,707	13,945	14,448	30	42	31	44	98	85	-54	-41
Stewart	.	.	.	.	.	.	.	.	.	.	.	.	.	.
Sullivan	242,753	665	831	417,761	423,735	435,560	675	843	693	867	1,056	769	-189	98
Sumner	48,799	134	167	115,476	119,215	126,486	138	173	146	183	303	213	-120	-30
Tipton	4,341	12	20	12,974	13,252	13,875	12	20	13	21	100	44	-79	-23
Trousdale	1,678	5	10	2,060	2,117	2,220	5	10	5	10	25	21	-15	-11
Unicoi	4,283	12	20	6,172	6,198	6,244	12	20	12	20	48	7	-28	13

ACUTE-CARE BED NEED PROJECTIONS FOR 2014 AND 2018, BASED ON FINAL 2012 HOSPITAL JARS

COUNTY	2012		CURRENT	SERVICE AREA POPULATION			PROJECTED		PROJECTED		2012 ACTUAL BEDS		SHORTAGE/SURPLUS	
	INPATIENT DAYS	ADC	NEED	2012	2014	2018	ADC-2014	NEED 2014	ADC-2018	NEED 2018	LICENSED	STAFFED	LICENSED	STAFFED
Union	.	.	.	.	.	.	.	.	.	.	.	.	.	.
Van Buren	.	.	.	.	.	.	.	.	.	.	.	.	.	.
Warren	11,619	32	45	21,743	21,931	22,287	32	45	33	46	125	48	-79	-2
Washington	167,908	460	575	202,955	206,820	214,435	469	586	486	608	581	581	27	27
Wayne	1,990	6	11	4,701	4,683	4,647	5	11	5	11	80	32	-69	-21
Weakley	6,398	18	27	17,299	17,478	17,808	18	27	18	28	100	65	-72	-37
White	7,122	20	30	10,543	10,722	11,141	20	30	21	31	60	44	-29	-13
Williamson	31,464	86	108	99,271	103,289	111,805	90	112	97	121	185	185	-64	-64
Wilson	34,781	95	119	56,265	58,335	62,267	99	124	105	132	245	245	-113	-113

Source: Tennessee Department of Health, Division of Policy, Planning and Assessment, Office of Health Statistics. 11/14/2013

Data from Final JAR-Hospitals Schedules F and G. Underlying Tennessee population estimates and projections (2013 Series) from Office of Health Statistics. Projections and estimates for other states obtained from those states.

Project-Specific Review Criteria: Construction, Renovation, Expansion, and Replacement of Health Care Institutions

1. Any project that includes the addition of beds, services, or medical equipment will be reviewed under the standards for those specific activities.

In the preceding section of this response, the applicant has addressed the criteria for addition of licensed beds.

2. For relocation or replacement of an existing licensed healthcare institution:
a. The applicant should provide plans that include costs for both renovation and relocation, demonstrating the strengths and weaknesses of each alternative.
b. The applicant should demonstrate that there is an acceptable existing or projected future demand for the proposed project.

Not applicable; the project does not replace an existing facility.

3. For renovation or expansion of an existing licensed healthcare institution:
a. The applicant should demonstrate that there is an acceptable existing demand for the proposed project.

The utilization assumptions on which project utilization is based have all been more conservative than actual experience in recent years, for both the Emergency Department visits and the Joint Replacement Program's surgical case growth. Section B.II.C. above provides details of present and future demand for both the ED and surgical area improvements.

The Emergency Department needs a more functional workflow, more specialized treatment rooms, improved accessibility for ambulances, privacy for family consultations, treatment rooms with more privacy, and other improvements. The imminent arrival on campus of a large regionally known joint replacement surgery group makes it imperative to provide all CMC surgeons in this field of service with a dedicated Center of Excellence in which patients can be more efficiently served, improving outcomes and the productivity of the program. It is desirable for the Center to offer block scheduling of two rooms at a time for these surgical teams, and for their patients to have immediate access to post-surgical rehabilitation and care in a dedicated nursing unit with specialized staff and facilities.

b. the applicant should demonstrate that the existing physical plant's condition warrants major renovation or expansion.

This is not a renovation project to remedy an aging facility; it is a renovation and expansion for the purposes of providing needed new surgical environments for joint replacement patients. The need for this has been demonstrated in Section B.II.B above and in the responses in this set of criteria.

The Framework for Tennessee's Comprehensive State Health Plan

Five Principles for Achieving Better Health

The following Five Principles for Achieving Better Health serve as the basic framework for the State Health Plan. After each principle, the applicant states how this CON application supports the principle, if applicable.

1. Healthy Lives

The purpose of the State Health Plan is to improve the health of Tennesseans.
Every person's health is the result of the interaction of individual behaviors, society, the environment, economic factors, and our genetic endowment. The State Health Plan serves to facilitate the collaboration of organizations and their ideas to help address health at these many levels.

The project is intended to improve not only the efficiency of Joint Replacement surgery, but also to continue to improve clinical quality of care through creating a setting in which all clinical personnel involved in every phase of this type of patient's care can continuously, and collaboratively, monitor, measure, study, and improve clinical outcomes for this very vulnerable class of patient.

2. Access to Care

Every citizen should have reasonable access to health care.
Many elements impact one's access to health care, including existing health status, employment, income, geography, and culture. The State Health Plan can provide standards for reasonable access, offer policy direction to improve access, and serve a coordinating role to expand health care access.

Centennial offers broad access to joint replacement services, being contracted to Medicare, to all available area TennCare MCO's, and to most of the area' many commercial insurance plans.

3. Economic Efficiencies

The state's health care resources should be developed to address the needs of Tennesseans while encouraging competitive markets, economic efficiencies and the continued development of the state's health care system. **The State Health Plan should work to identify opportunities to improve the efficiency of the state's health care system and to encourage innovation and competition.**

The ten specialized, oversize operating rooms will allow block scheduling of two rooms per surgical team, which allows each team to complete surgery in one room and then move quickly into an adjoining room that is already prepared for the next case to start. This avoids imposing unproductive downtime in waiting for a room to be cleared,

cleaned, and prepared for the next case. The alternating use of two rooms (called "flipping" the rooms) makes the entire team more productive. It allows for more cases to be completed per day. It supports maximum case completion early in the week so that patients can more quickly begin early rehabilitation before the weekend removes most rehabilitation staff from the hospital. That can shorten stays for many patients, enabling them to be stronger upon discharge to home or to a specialized rehabilitation facility.

4. Quality of Care

Every citizen should have confidence that the quality of health care is continually monitored and standards are adhered to by health care providers. **Health care providers are held to certain professional standards by the state's licensure system. Many health care stakeholders are working to improve their quality of care through adoption of best practices and data-driven evaluation.**

Centennial Medical Center and its caregiver teams and surgical staff observe high standards of professional preparation, competence, and care. The hospital and its parent company are heavily committed to identifying and implementing best practices though continuous data-driven evaluation.

5. Health Care Workforce

The state should support the development, recruitment, and retention of a sufficient and quality health care workforce. **The state should consider developing a comprehensive approach to ensure the existence of a sufficient, qualified health care workforce, taking into account issues regarding the number of providers at all levels and in all specialty and focus areas, the number of professionals in teaching positions, the capacity of medical, nursing, allied health and other educational institutions, state and federal laws and regulations impacting capacity programs, and funding.**

The applicant's numerous affiliations with health professions training programs contribute yearly to the development of the healthcare workforce. These programs are listed in Section C.III.6 of this application.

C(I).2. DESCRIBE THE RELATIONSHIP OF THIS PROJECT TO THE APPLICANT'S LONG-RANGE DEVELOPMENT PLANS, IF ANY.

TriStar Centennial Medical Center continuously updates its development plans through regular community need assessments, service capacity analyses, and facility planning projects. The potential for expanding Centennial's Joint Replacement program was indicated by regional and local market trends in joint replacement surgeries; and this specific project was designed to provide an optimal setting for an integrated service continuum for the joint replacement patient.

C(I).3. IDENTIFY THE PROPOSED SERVICE AREA AND JUSTIFY THE REASONABLENESS OF THAT PROPOSED AREA. SUBMIT A COUNTY-LEVEL MAP INCLUDING THE STATE OF TENNESSEE CLEARLY MARKED TO REFLECT THE SERVICE AREA. PLEASE SUBMIT THE MAP ON A 8-1/2" X 11" SHEET OF WHITE PAPER MARKED ONLY WITH INK DETECTABLE BY A STANDARD PHOTOCOPIER (I.E., NO HIGHLIGHTERS, PENCILS, ETC.).

Table Thirteen on the next page suggests that based on the applicant's CY2013 inpatient origin, the service area of the project will consist of eight contiguous Middle Tennessee counties: Davidson County (Nashville) and Rutherford, Sumner, Cheatham, Williamson, Montgomery, Wilson, and Robertson Counties.

Approximately 68% of all hospital admissions came from those counties last year. The hospital's medical-surgical admissions had the same counties as their primary service area. The applicant believes that this service area will be the same for its Joint Replacement Center and its 29-bed specialized inpatient unit.

A service area map and a map showing the location of the service within the State of Tennessee are provided as Attachments C, Need--3 at the back of the application.

Table Thirteen: Patient Origin Projection--CMC Joint Replacement Center Program and Inpatient Nursing Unit					
County	Inpatient Admissions CY2013	Percent of Total Admissions	Cumulative Percent of Total Admissions	Joint Replacement Center Admissions Yr 1-2016	Joint Replacement Center Admissions Yr 2-2017
CMC Primary Service Area ("PSA") Counties					
Davidson	10,742	38.28%	38.28%	1,098	1,148
Rutherford	1,611	5.74%	44.02%	165	172
Sumner	1,582	5.64%	49.65%	162	169
Cheatham	1,372	4.89%	54.54%	140	147
Williamson	1,342	4.78%	59.33%	137	143
Montgomery	901	3.21%	62.54%	92	96
Wilson	766	2.73%	65.27%	78	82
Robertson	789	2.81%	68.08%	81	84
PSA Subtotal	*19,105*	*68.08%*		*1,953*	*2,042*
Secondary Service Area ("SSA") Counties and States					
84 Other TN Counties <2.8%	7,208	25.68%	93.76%	737	770
>8 Other States	1,751	6.24%	100.00%	179	187
SSA Subtotal	*8,959*	*31.92%*		*916*	*957*
Grand Total	*28,064*	*100.00%*		*2,869*	*2,999*

Source: Hospital records and management projections. Admissions data rounded.

C(I).4.A DESCRIBE THE DEMOGRAPHICS OF THE POPULATION TO BE SERVED BY THIS PROPOSAL.

As shown on Table Fourteen on the next page, over the next four years this eight-county Middle Tennessee service area's total population is projected to increase at almost twice the rate of the State--6.9% compared to 3.7% Statewide.

Of particular interest is the service area's aged population, which is the age cohort that most heavily utilizes joint replacement surgery. This service area's elderly (65+) population is projected to increase more slowly than the State's elderly population from 2014 to 2018 (11.3% increase compared to 14.9% Statewide).

However, to put this in perspective, the area's elderly population will still increase by almost 35,000 persons in the next four years--which is more than the total population of all ages, projected for 45 of the State's 95 counties. And the elderly are not the only age cohort utilizing joint replacement services. Many persons age 50-65 also frequently seek such procedures as knee replacements.

In terms of income, this service area is relatively fortunate compared to the rest of Tennessee. The area average income is substantially higher; the percent of its population that is enrolled in TennCare is lower; and the percent of its population living below the poverty level is smaller.

Table Fourteen: Demographic Characteristics of Primary Service Area
Centennial Medical Center
2014-2018

Demographic	CHEATHAM County	DAVIDSON County	MONTGOMERY County	ROBERTSON County	RUTHERFORD County	SUMNER County	WILLIAMSON County	WILSON County	TENNESSEE PSA	STATE OF TENNESSEE
Median Age-2010 US Census	39.3	33.9	30.0	37.6	32.2	38.6	38.5	39.3	36	38.0
Total Population-2014	39,853	656,385	187,649	70,391	293,582	172,262	202,923	124,073	1,747,118	6,588,698
Total Population-2018	40,765	682,330	200,561	74,371	329,446	183,406	223,333	133,357	1,867,569	6,833,509
Total Population-% Change 2014 to 2018	2.3%	4.0%	6.9%	5.7%	12.2%	6.5%	10.1%	7.5%	6.9%	3.7%
Age 65+ Population-2014	4,905	74,375	16,292	8,126	27,218	25,164	23,028	17,944	197,052	981,984
% of Total Population	12.3%	11.3%	8.7%	11.5%	9.3%	14.6%	11.3%	14.5%	11.3%	14.9%
Age 65+ Population-2018	5,769	85,594	18,946	9,221	33,222	29,697	27,729	21,745	231,923	1,102,413
% of Total Population	14.2%	12.5%	9.4%	12.4%	10.1%	16.2%	12.4%	16.3%	12.4%	16.1%
Age 65+ Population-% Change 2014-2018	17.6%	15.1%	16.3%	13.5%	22.1%	18.0%	20.4%	21.2%	17.7%	12.3%
Median Household Income	$53,363	$46,676	$49,459	$52,588	$55,105	$55,560	$91,146	$61,353	$58,156.25	$44,140
TennCare Enrollees (2/14)	6,306	120,575	24,607	11,061	37,409	23,392	8,790	14,652	246,792	1,211,113
Percent of 2014 Population Enrolled in TennCare	15.8%	18.4%	13.1%	15.7%	12.7%	13.6%	4.3%	11.8%	14.1%	18.4%
Persons Below Poverty Level (2014)	4,663	121,431	30,399	9,151	38,166	16,882	11,770	11,539	244,000	1,139,845
Persons Below Poverty Level As % of Population (US Census)	11.7%	18.5%	16.2%	13.0%	13.0%	9.8%	5.8%	9.3%	14.0%	17.3%

Sources: TDH Population Projections, May 2013; U.S. Census QuickFacts and FactFinder2; TennCare Bureau. PSA data is unweighted average or total of county data.

C(I).4.B. DESCRIBE THE SPECIAL NEEDS OF THE SERVICE AREA POPULATION, INCLUDING HEALTH DISPARITIES, THE ACCESSIBILITY TO CONSUMERS, PARTICULARLY THE ELDERLY, WOMEN, RACIAL AND ETHNIC MINORITIES, AND LOW-INCOME GROUPS. DOCUMENT HOW THE BUSINESS PLANS OF THE FACILITY WILL TAKE INTO CONSIDERATION THE SPECIAL NEEDS OF THE SERVICE AREA POPULATION.

Like other services of TriStar Centennial Medical Center, this proposed Joint Replacement Center of Excellence and its associated orthopedic inpatient unit will be accessible to the above groups. TriStar accepts both Medicare and TennCare patients. The Centennial Emergency Department treats every person who presents with the need for emergency medical care, regardless of age, gender, racial or minority status, income, or insurance coverage.

C(I).5. DESCRIBE THE EXISTING OR CERTIFIED SERVICES, INCLUDING APPROVED BUT UNIMPLEMENTED CON'S, OF SIMILAR INSTITUTIONS IN THE SERVICE AREA. INCLUDE UTILIZATION AND/OR OCCUPANCY TRENDS FOR EACH OF THE MOST RECENT THREE YEARS OF DATA AVAILABLE FOR THIS TYPE OF PROJECT. BE CERTAIN TO LIST EACH INSTITUTION AND ITS UTILIZATION AND/OR OCCUPANCY INDIVIDUALLY. INPATIENT BED PROJECTS MUST INCLUDE THE FOLLOWING DATA: ADMISSIONS OR DISCHARGES, PATIENT DAYS, AND OCCUPANCY. OTHER PROJECTS SHOULD USE THE MOST APPROPRIATE MEASURES, E.G., CASES, PROCEDURES, VISITS, ADMISSIONS, ETC.

The only publicly available source for this data is the Department of Health's Joint Annual Report ("JAR") for each hospital. Table Fifteen on the following page provides JAR inpatient utilization data for all the primary service area hospitals that provide general acute care. Table Fifteen excludes hospitals that are dedicated to psychiatric, rehabilitation, or long-term acute care, because those are not institutions similar to TriStar Centennial Medical Center.

There are eighteen similar hospitals in the eight-county primary service area. During the past three years, JAR data on their licensed bed occupancy as a group has held constant at approximately 57%, while their total licensed bed complements as a group changed from 4,826 beds to 4,994 beds, a net increase of 3.5%.

This data, however, is inadequate for making informed health planning decisions. The JAR does not have comprehensive utilization data for every bed category within a hospital, and the JAR does not include data on observation patients' bed days. These are significant shortcomings.

For example, using JAR admissions data, in CY2013 TriStar Centennial Medical Center's total bed occupancy was 65.1% and its medical-surgical occupancy was 70.6%. However, if observation patients (who are reimbursed and treated) are included, Centennial had an overall bed occupancy of 71.7% and a medical-surgical bed occupancy of 82.8%--significantly higher than the incomplete JAR data suggests.

In the following section of the application, Centennial provides total bed day utilization data in its Table Sixteen-C.

Table Fifteen: General Acute Care Hospital Utilization in Primary Service Area 2011-2013

2011 Joint Annual Reports of Hospitals

State ID	Facility Name	County	Licensed Beds	Admissions	Days	Avg Length of Stay (Days)	Avg Daily Census (Patients)	Occupancy on Licensed Beds
	TriStar Ashland City Medical Center	Cheatham	12	182	1,567	8.6	4	35.8%
	Metro NV General Hospital	Davidson	150	4,570	21,027	4.6	58	38.4%
	Saint Thomas Hospital for Spinal Surgery	Davidson	23	1,127	1,505	1.3	4	17.9%
	Saint Thomas Midtown Hospital (Baptist)	Davidson	683	24,448	113,135	4.6	310	45.4%
	Saint Thomas West Hospital	Davidson	541	22,623	102,534	4.5	281	51.9%
	TriStar Centennial Medical Center	Davidson	606	23,187	139,114	6.0	381	62.9%
	TriStar Skyline Medical Center, Nashville	Davidson	213	9,152	51,710	5.7	142	66.5%
	TriStar Southern Hills Medical Center	Davidson	120	3,548	15,693	4.4	43	35.8%
	TriStar Summit Medical Center	Davidson	188	9,984	39,877	4.0	109	58.1%
	Vanderbilt Medical Center	Davidson	916	49,174	275,500	5.6	755	82.4%
	Gateway Medical Center	Montgomery	270	11,337	43,753	3.9	120	44.4%
	Northcrest Medical Center	Robertson	109	4,173	17,535	4.2	48	44.1%
	Saint Thomas Rutherford Hospital	Rutherford	286	16,488	69,118	4.2	189	66.2%
	TriStar Stonecrest Medical Center	Rutherford	101	4,604	14,082	3.1	39	38.2%
	Sumner Regional Medical Center	Sumner	155	6,566	26,274	4.0	72	46.4%
	TriStar Hendersonville Medical Center	Sumner	110	4,748	18,732	3.9	51	46.7%
	Williamson Medical Center	Williamson	185	8,446	33,241	3.9	91	49.2%
	University Medical Center (UMC)	Wilson	170	5,719	25,679	4.5	70	41.4%
	SERVICE AREA TOTALS		**4,826**	**209,894**	**1,008,509**	**4.8**	**2,763**	**57.3%**

2012 Joint Annual Reports of Hospitals

State ID	Facility Name	County	Licensed Beds	Admissions	Days	Avg Length of Stay (Days)	Avg Daily Census (Patients)	Occupancy on Licensed Beds
	TriStar Ashland City Medical Center	Cheatham	12	194	1,551	8.0	4	35.4%
	Metro NV General Hospital	Davidson	150	4,069	17,401	4.3	48	31.8%
	Saint Thomas Hospital for Spinal Surgery	Davidson	23	1,144	1,519	1.3	4	18.1%
	Saint Thomas Midtown Hospital (Baptist)	Davidson	683	24,189	112,163	4.6	307	45.0%
	Saint Thomas West Hospital	Davidson	541	22,621	100,202	4.4	275	50.7%
	TriStar Centennial Medical Center	Davidson	606	25,830	147,903	5.7	405	66.9%
	TriStar Skyline Medical Center, Nashville	Davidson	213	9,773	52,021	5.3	143	66.9%
	TriStar Southern Hills Medical Center	Davidson	120	4,077	17,845	4.4	49	40.7%
	TriStar Summit Medical Center	Davidson	188	10,779	42,722	4.0	117	62.3%
	Vanderbilt Medical Center	Davidson	916	50,240	275,013	5.5	753	82.3%
	Gateway Medical Center	Montgomery	270	11,248	41,483	3.7	114	42.1%
	Northcrest Medical Center	Robertson	109	3,836	15,747	4.1	43	39.6%
	Saint Thomas Rutherford Hospital	Rutherford	286	16,256	65,205	4.0	179	62.5%
	TriStar Stonecrest Medical Center	Rutherford	101	4,934	15,472	3.1	42	42.0%
	Sumner Regional Medical Center	Sumner	155	6,790	27,948	4.1	77	49.4%
	TriStar Hendersonville Medical Center	Sumner	110	5,551	20,434	3.7	56	50.9%
	Williamson Medical Center	Williamson	185	8,114	31,518	3.9	86	46.7%
	University Medical Center (UMC)	Wilson	170	5,528	24,279	4.4	67	39.1%
	SERVICE AREA TOTALS		**4,826**	**214,979**	**1,008,875**	**4.7**	**2,764**	**57.3%**

2013 Joint Annual Reports of Hospitals

Facility Name	County	Licensed Beds	Admissions	Days	Avg Length of Stay (Days)	Avg Daily Census (Patients)	Occupancy on Licensed Beds
TriStar Ashland City Medical Center	Cheatham	12	197	1,397	7.1	4	31.9%
Metro Nashville General Hospital	Davidson	150	3,517	16,088	4.6	44	29.4%
Saint Thomas Hospital for Spinal Surgery	Davidson	23	1,120	1,485	1.3	4	17.7%
Saint Thomas Midtown Hospital (Baptist)	Davidson	683	24,105	110,408	4.6	302	44.3%
Saint Thomas West Hospital	Davidson	541	21,386	99,877	4.7	274	50.6%
TriStar Centennial Medical Center	Davidson	657	28,061	156,094	5.6	428	65.1%
TriStar Skyline Medical Center	Davidson	213	10,024	55,811	5.6	153	71.8%
TriStar Southern Hills Medical Center	Davidson	126	4,209	20,068	4.8	55	43.6%
TriStar Summit Medical Center	Davidson	188	10,636	43,122	4.1	118	62.8%
Vanderbilt Medical Center	Davidson	1,019	53,957	298,505	5.5	818	80.3%
Gateway Medical Center	Montgomery	270	9,804	36,609	3.7	100	37.1%
Northcrest Medical Center	Robertson	109	3,230	13,916	4.3	38	35.0%
Saint Thomas Rutherford Hospital	Rutherford	286	16,176	63,503	3.9	174	60.8%
TriStar Stonecrest Medical Center	Rutherford	109	5,124	16,254	3.2	45	40.9%
Sumner Regional Medical Center	Sumner	155	7,529	32,682	4.3	90	57.8%
TriStar Hendersonville Medical Center	Sumner	110	5,828	20,567	3.5	56	51.2%
Williamson Medical Center	Williamson	185	7,981	30,171	3.8	83	44.7%
University Medical Center (UMC)	Wilson	170	5,080	22,423	4.4	61	36.1%
SERVICE AREA TOTALS		**4,794**	**217,967**	**1,038,980**	**4.8**	**2,847**	**57.0%**

Note: Tables exclude dedicated rehabilitation, long-term acute, and psychiatric facilities, and unstaffed facilities. Licensed beds on p. 22 of the JARs are as of the last day of the year; they may differ from current CY2014 licensure.

C(I).6. PROVIDE APPLICABLE UTILIZATION AND/OR OCCUPANCY STATISTICS FOR YOUR INSTITUTION FOR EACH OF THE PAST THREE (3) YEARS AND THE PROJECTED ANNUAL UTILIZATION FOR EACH OF THE TWO (2) YEARS FOLLOWING COMPLETION OF THE PROJECT. ADDITIONALLY, PROVIDE THE DETAILS REGARDING THE METHODOLOGY USED TO PROJECT UTILIZATION. THE METHODOLOGY MUST INCLUDE DETAILED CALCULATIONS OR DOCUMENTATION FROM REFERRAL SOURCES, AND IDENTIFICATION OF ALL ASSUMPTIONS.

I. Emergency Department

Table Sixteen-A below (repeating the data in Table Ten-A above) provides historical and projected data on visits to CMC's Tower Emergency Department, the main ED for the hospital. (As described earlier, there is an ED at the Centennial Women's and Children's Hospital on the same campus, but that is not utilized for higher acuity visits; and there is a satellite ED at Spring Hill. At the Tower ED, visits have increased at a compound average growth rate of more than 8% per year since 2010. In projecting ED visits for this application, Table Sixteen uses a conservative 5% annual increase (CAGR) through Year Two of the project. That year the ED's average visits per room in CY2017 are conservatively projected to be 1,781 visits per treatment room (42,746 / 24).

Table Sixteen-A: Annual Visits to the Tower Emergency Department TriStar Centennial Medical Center

Year	Annual Visits		Annual Change, Tower Visits
	Tower ED	All 3 CMC ED's	
Historical			
2010	27,350	32,101	--
2011	27,482	34,534	+0.5%
2012	31,124	38,774	+13.3%
2013	35,168	48,146	+13.0%
2010-2013 Total Change			*+28.6%*
2010-2013 CAGR			*> 8% CAGR*
Projected (at 5% CAGR)			
2014	36,926		+5%
2015	38,772		+5%
Project Year 1 - 2016	40,711		+5%
Project Year 2 - 2017	42,746		+5%

Source: Tower ED visits from CMC Management; total CMC visits from JAR.

Table Sixteen-B below provides CY2013 acuity levels of visits to the Tower ED, and projects the acuity mix in Years One and Two based on the same distribution as in CY2013.

Table Sixteen-B: Centennial Medical Center Main Emergency Department Historic and Projected Visits By Level of Acuity				
ED Visits by Assigned HCA Acuity Level	**CY2013**	**Percent of Total Visits**	**Projected Visits CY2016**	**Projected Visits CY2017**
Level I	515	1.5%	611	641
Level II	1,645	4.7%	1,913	2,009
Level III	13,819	39.3%	15,959	16,756
Level IV	9,902	28.2%	11,481	12,054
Level V	9,287	26.4%	10,748	11,285
Trauma	0	0.0%	0	0
Totals	35,168	100.0%	40,711	42,746
Treatment Stations	28			24
Visits Per Station	1,256			1,781

Source: Hospital records for CY2013. Projected total visits from Table Sixteen-A. Projected visits by acuity distributed based on CY2013 percentages.

The ED Levels of Care in this table, and on the Frequent Charges table later in the application, are the applicant's parent company's system of classifying acuity. They reflect acuity of care as defined by resource consumption for patients—Level I being the least costly, least intense care; Level V being the highest classification short of Critical Care. There is no other acuity indicator recorded in the company's database.

II. Acute Care Bed Utilization

Table Sixteen-C below provides historic (2011-2013) and projected (2014-2017) utilization for TriStar Centennial's medical-surgical bed utilization. Table Sixteen-C includes all bed days--days of formally admitted patients, and also days of "observation" patients. Average daily census, and average annual occupancy, are calculated based on those total days.

Exhibit Sixteen-C: Historic and Projected Medical-Surgical Bed Utilization TriStar Centennial Medical Center CY2011-CY2017

Year	Med-Surg Beds	Med-Surg Bed Annual Capacity	Total Bed Days	Avg. Daily Census on Total Days	Total Average Occupancy
Historic					
CY2011	258	94,170	69,558	190.6	73.9%
CY2012	281	102,846	81,423	222.5	79.2%
CY2013	281	102,565	84,959	232.8	82.8%
Projected					
CY2014	281	102,565	89,553	245.4	87.3%
CY2015	281	102,565	98,669	258.0	96.2%
Yr 1 CY2016	310	113,460	103,774	284.3	91.7%
Yr 2 CY2017	310	113,150	109,149	299.0	96.5%

Source: Table Sixteen-C. CY2012 and CY2016 are 366-day leap years.

The data for Table Sixteen-C are taken from the more comprehensive Table Sixteen-D on the following page, which provides detailed utilization data on all categories of licensed beds at TriStar Centennial Medical Center.

The graph on the second following page illustrates the frequency with which medical-surgical bed occupancies exceeded 85% over the past months. The horizontal lines across the line graph indicate the 85% occupancy levels on both the current (281) and the proposed (310) medical-surgical bed complements.

Table Sixteen-D: Centennial Medical Center
Actual and Projected Licensed Bed Utilization, CY2011-2017

	Actual '11	Actual '12	Actual '13	Projected '14	Projected 2015	Year One Projected 2016	Year Two Projected 2017
Total Beds	606	657	657	657	657	686	686
Discharges	23,187	25,830	28,064	28,769	32,128	34,216	36,448
Discharge Days	139,114	147,903	156,094	164,289	176,748	186,299	197,886
ALOS on Discharges	6.0	5.7	5.6	5.7	5.5	5.4	5.4
ADC on Discharges	381.1	404.1	427.7	450.1	484.2	510.4	542.2
Occupancy on Discharges	62.9%	61.5%	65.1%	68.5%	73.7%	74.4%	79.0%
23-Hour Observation Days	7,198	17,202	15,941	18,207	18,959	19,755	20,599
Total Bed Days	146,312	165,105	172,034	182,496	195,707	206,054	218,485
Total ADC	400.9	451.1	471.3	500.0	536.2	564.5	598.6
Total Occupancy	66.1%	68.7%	71.7%	76.1%	81.6%	82.3%	87.3%
Medical-Surgical Beds	258	281	281	281	281	310	310
Discharges	12,325	13,784	14,935	14,928	17,440	18,623	19,886
Discharge Days	63,894	67,887	72,415	75,226	83,849	88,444	93,291
ALOS on Discharges	5.2	4.9	4.8	5.0	4.8	4.7	4.7
ADC on Discharges	175.1	185.5	198.4	206.1	229.7	242.3	255.6
Occupancy on Discharges	67.8%	66.0%	70.6%	73.3%	81.8%	78.2%	82.4%
23-Hour Observation Days	5,664	13,536	12,545	14,327	14,820	15,330	15,858
Total Bed Days	69,558	81,423	84,959	89,553	98,669	103,774	109,149
Total ADC	190.6	222.5	232.8	245.4	270.3	284.3	299.0
Total Occupancy	73.9%	79.2%	82.8%	87.3%	96.2%	91.7%	96.5%
ICU/CCU Beds	83	88	88	88	88	88	88
Discharges	3,655	4,123	4,412	4,488	4,814	5,163	5,538
Discharge Days	17,418	18,024	17,980	19,099	19,683	20,284	20,904
ALOS on Discharges	4.8	4.4	4.1	4.3	4.1	3.9	3.8
ADC on Discharges	47.7	49.2	49.3	52.3	53.9	55.6	57.3
Occupancy on Discharges	57.5%	56.0%	56.0%	59.5%	61.3%	63.2%	65.1%
23-Hour Observation Days	379	907	840	960	993	1,027	1,062
Total Bed Days	17,797	18,931	18,820	20,059	20,676	21,311	21,966
Total ADC	48.8	51.7	51.6	55.0	56.6	58.4	60.2
Total Occupancy	58.7%	58.8%	58.6%	62.5%	64.4%	66.3%	68.4%
Pediatric Beds	11	21	21	21	21	21	21
Discharges	23	354	869	965	1,074	1,195	1,330
Discharge Days	59	686	1,710	2,767	4,485	7,270	11,784
ALOS on Discharges	2.6	1.9	2.0	2.9	4.2	6.1	8.9
ADC on Discharges	0.2	1.9	4.7	7.6	12.3	19.9	32.3
Occupancy on Discharges	1.5%	8.9%	22.3%	36.1%	58.5%	94.8%	153.7%
23-Hour Observation Days	462	1,103	1,022	1,168	1,335	1,526	1,744
Total Bed Days	521	1,789	2,732	3,935	5,820	8,796	13,528
Total ADC	1.4	4.9	7.5	10.8	15.9	24.1	37.1
Total Occupancy	13.0%	23.3%	35.6%	51.3%	75.9%	114.8%	176.5%
Obstetrical/GYN Beds	62	75	75	75	75	75	75
Discharges	3,015	3,283	3,603	3,672	3,926	4,198	4,488
Discharge Days	9,936	11,313	11,197	10,663	10,941	11,226	11,519
ALOS on Discharges	3.3	3.4	3.1	2.9	2.8	2.7	2.6
ADC on Discharges	27.2	30.9	30.7	29.2	30.0	30.8	31.6
Occupancy on Discharges	43.9%	41.2%	40.9%	39.0%	40.0%	41.0%	42.1%
23-Hour Observation Days	663	1,584	1,468	1,676	1,733	1,792	1,853
Total Bed Days	10,599	12,897	12,665	12,339	12,674	13,018	13,372
Total ADC	29.0	35.2	34.7	33.8	34.7	35.7	36.6
Total Occupancy	46.8%	47.0%	46.3%	45.1%	46.3%	47.6%	48.8%
NICU Beds	60	60	60	60	60	60	60
Discharges	535	664	664	715	733	751	770
Discharge Days	13,009	15,293	17,967	19,454	19,940	20,439	20,950
ALOS on Discharges	24.3	23.0	27.1	27.2	27.2	27.2	27.2
ADC on Discharges	35.6	41.8	49.2	53.3	54.6	56.0	57.4
Occupancy on Discharges	59.4%	69.6%	82.0%	88.8%	91.1%	93.3%	95.7%
23-Hour Observation Days	14	33	30	35	36	37	38
Total Bed Days	13,023	15,326	17,997	19,489	19,976	20,476	20,988
Total ADC	35.7	41.9	49.3	53.4	54.7	56.1	57.5
Total Occupancy	59.5%	69.8%	82.2%	89.0%	91.2%	93.5%	95.8%
Psychiatric Beds	132	132	132	132	132	132	132
Discharges	3,634	3,622	3,581	4,001	4,141	4,286	4,436
Discharge Days	34,798	34,700	34,825	37,080	37,850	38,636	39,438
ALOS on Discharges	9.6	9.6	9.7	9.3	9.1	9.0	8.9
ADC on Discharges	95.3	94.8	95.4	101.6	103.7	105.9	108.0
Occupancy on Discharges	72.2%	71.8%	72.3%	77.0%	78.6%	80.2%	81.9%
23-Hour Observation Days	16	39	36	41	42	43	44
Total Bed Days	34,814	34,739	34,861	37,121	37,892	38,679	39,482
Total ADC	95.4	94.9	95.5	101.7	103.8	106.0	108.2
Total Occupancy	72.3%	71.9%	72.4%	77.0%	78.6%	80.3%	81.9%

Source: Joint Annual Reports; Hospital records; projections by hospital management.

Assumptions for Projections in Table Sixteen-D

The discharges, patient days, and observation days in the table were projected through CY2017 by using their 2011-2014 three-year average annual growth rate, for the bed categories of ICU/CCU, OB/Gyn, and Psychiatric beds:

Three-Year Average Growth Rates (2011-12; 2012-13; 2013-14 Annualized)			
Bed Category	**Average Rate For Discharges**	**Average Rate For Patient Days**	**Average Rate For Observation Days**
ICU/CCU	7.26%	3.06%	3.45%
OB/Gyn	6.92%	2.61%	3.42%
Psychiatric	3.51%	2.08%	3.10%

Pediatric and NICU beds at Centennial have capacity limitations that would make it unrealistic to project discharges and days using the triple-digit growth rates of 2011-2013. For Pediatric beds, the most recent 2013-2014 rates of 11.3% and 62.1% were used for discharges and patient days respectively, reflecting an increasingly acute pediatric patient. Observation days were projected using the 3.47% 3-year average growth rate in this service. The projections indicate reaching more than 100% overall bed occupancies in 2016 and 2017. Over the next two years this will be monitored and can be addressed by reassigning available gynecologic beds in the same building as necessary.

The medical-surgical bed utilization was projected by using the three-year average growth rates of 6.78% and 5.48% for discharges and patient days, and 3.45% for observation days--and also by increasing the discharges and days in 2015 by the cases and days being added to the hospital by SJRI physicians beginning in January 2015.

III. Operating Room Utilization

Tables Sixteen-E and -F on the following pages provide historical and projected operating room utilization data for the entire campus, at all locations. The utilization projections and assumptions for the 8th floor Operating Suite in the Joint Center were provided above in Table Ten-C. They are included again after Table Sixteen-B, for ease of reference.

Table Sixteen-E: Centennial Medical Center--Total Nashville Campus
Historical and Projected Operating Room Utilization
(Excludes Cardiovascular Suites)
2011-2017

TOTAL CAMPUS	Actual 2011	Actual 2012	Actual 2013	Projected 2014	Projected 2015	Year 1 Projected 2016	Year 2 Projected 2017
Number of O.R.'s	37	43	43	43	44	54	54
IP Cases	7,889	8,517	9,093	9,177	10,952	11,627	12,349
OP Cases	10,489	10,985	11,699	12,580	13,335	14,135	14,983
Total Cases	18,378	19,502	20,792	21,757	24,287	25,761	27,332
Cases Per O.R.	497	454	484	506	552	477	506

Tower	Actual 2011	Actual 2012	Actual 2013	Projected 2014	Projected 2015	Year 1 Projected 2016	Year 2 Projected 2017
Number of O.R.'s	17	17	17	17	17	27	27
IP Cases	5,667	5,214	5,290	5,256	6,914	7,467	8,064
OP Cases	2,794	2,729	2,781	2,857	3,028	3,210	3,403
Total Cases	8,461	7,943	8,071	8,113	9,942	10,677	11,467
Cases Per O.R.	498	467	475	477	585	395	425

Women's & Children's	Actual 2011	Actual 2012	Actual 2013	Projected 2014	Projected 2015	Year 1 Projected 2016	Year 2 Projected 2017
Number of O.R.'s	12	13	13	13	13	13	13
IP Cases	1,188	1,305	1,576	1,634	1,683	1,734	1,786
OP Cases	5,537	5,979	6,494	7,099	7,525	7,976	8,455
Total Cases	6,725	7,284	8,070	8,733	9,208	9,710	10,241
Cases Per O.R.	560	560	621	672	708	747	788

Atrium	Actual 2011	Actual 2012	Actual 2013	Projected 2014	Projected 2015	Year 1 Projected 2016	Year 2 Projected 2017
Number of O.R.'s	4	4	4	4	4	4	4
IP Cases	144	72	57	41	42	43	45
OP Cases	1,452	1,528	1,524	1,459	1,547	1,639	1,738
Total Cases	1,596	1,600	1,581	1,500	1,589	1,683	1,782
Cases Per O.R.	399	400	395	375	397	421	446

Sarah Cannon	Actual 2011	Actual 2012	Actual 2013	Projected 2014	Projected 2015	Year 1 Projected 2016	Year 2 Projected 2017
Number of O.R.'s	4	4	4	4	4	4	4
IP Cases	890	1,023	996	866	892	919	946
OP Cases	706	737	867	1,100	1,166	1,236	1,310
Total Cases	1,596	1,760	1,863	1,966	2,058	2,155	2,256
Cases Per O.R.	399	440	466	492	514	539	564

Heart & Vascular	Actual 2011	Actual 2012	Actual 2013	Projected 2014	Projected 2015	Year 1 Projected 2016	Year 2 Projected 2017
Number of O.R.'s	-	5	5	5	6	6	6
IP Cases	-	903	1,174	1,380	1,421	1,464	1,508
OP Cases	-	12	33	65	69	73	77
Total Cases	-	915	1,207	1,445	1,490	1,537	1,585
Cases Per O.R.	-	183	241	289	248	256	264

Source: Hospital records, management projections. Non-sterile procedure rooms and CV surgery rooms not included. Includes all sterile rooms.

Table Sixteen-F: CMC Operating Rooms--Current Efficiency		
All CMC Operating Rooms	**2013**	**2014 Annualized**
Number of Operating Rooms	43	43
Annual Cases	20,792	21,330
Average Cases per Room	484	496
Annual Minutes Used	2,478,207	2,572,377
Average Minutes Per Room	57,633	59,823
Annual Minutes Available Per Room	5,160,000	5,160,000
Average Percent O.R. Utilization	48.0%	49.9%

OR Group: Tower	2013	2014 Annualized
Number of Operating Rooms	17	17
Annual Cases	8,071	8,113
Average Cases per Room	475	477
Annual Minutes Used	1,029,719	1,037,175
Average Minutes Per Room	60,572	61,010
Annual Minutes Available Per Room	2,040,000	2,040,000
Average Percent O.R. Utilization	50.5%	50.8%

OR Group: Women's & Children's	2013	2014 Annualized
Number of Operating Rooms	13	13
Annual Cases	8,070	8,306
Average Cases per Room	621	639
Annual Minutes Used	689,386	738,853
Average Minutes Per Room	53,030	56,835
Annual Minutes Available Per Room	1,560,000	1,560,000
Average Percent O.R. Utilization	44.2%	47.4%

OR Group: Atrium	2013	2014 Annualized
Number of Operating Rooms	4	4
Annual Cases	1,581	1,500
Average Cases per Room	395	375
Annual Minutes Used	250,969	250,097
Average Minutes Per Room	62,742	62,524
Annual Minutes Available Per Room	480,000	480,000
Average Percent O.R. Utilization	52.3%	52.1%

OR Group: Sarah Cannon	2013	2014 Annualized
Number of Operating Rooms	4	4
Annual Cases	1,863	1,966
Average Cases per Room	466	492
Annual Minutes Used	213,016	222,198
Average Minutes Per Room	53,254	55,550
Annual Minutes Available Per Room	480,000	480,000
Average Percent O.R. Utilization	44.4%	46.3%

OR Group: Hearth & Vascular	2013	2014 Annualized
Number of Operating Rooms	5	5
Annual Cases	1,207	1,445
Average Cases per Room	241	289
Annual Minutes Used	295,117	324,054
Average Minutes Per Room	59,023	64,811
Annual Minutes Available Per Room	600,000	600,000
Average Percent O.R. Utilization	49.2%	54.0%

Source: Hospital records. Excludes non-sterile procedure rooms and CV rooms.
Notes: Cases = encounters on Joint Annual Reports. Available minutes calculated on 250 days per year, 8 hours per day, per room.

C(II)1. PROVIDE THE COST OF THE PROJECT BY COMPLETING THE PROJECT COSTS CHART ON THE FOLLOWING PAGE. JUSTIFY THE COST OF THE PROJECT.

• ALL PROJECTS SHOULD HAVE A PROJECT COST OF AT LEAST $3,000 ON LINE F (MINIMUM CON FILING FEE). CON FILING FEE SHOULD BE CALCULATED ON LINE D.

• THE COST OF ANY LEASE (BUILDING, LAND, AND/OR EQUIPMENT) SHOULD BE BASED ON FAIR MARKET VALUE OR THE TOTAL AMOUNT OF THE LEASE PAYMENTS OVER THE INITIAL TERM OF THE LEASE, WHICHEVER IS GREATER. NOTE: THIS APPLIES TO ALL EQUIPMENT LEASES INCLUDING BY PROCEDURE OR "PER CLICK" ARRANGEMENTS. THE METHODOLOGY USED TO DETERMINE THE TOTAL LEASE COST FOR A "PER CLICK" ARRANGEMENT MUST INCLUDE, AT A MINIMUM, THE PROJECTED PROCEDURES, THE "PER CLICK" RATE AND THE TERM OF THE LEASE.

• THE COST FOR FIXED AND MOVEABLE EQUIPMENT INCLUDES, BUT IS NOT NECESSARILY LIMITED TO, MAINTENANCE AGREEMENTS COVERING THE EXPECTED USEFUL LIFE OF THE EQUIPMENT; FEDERAL, STATE, AND LOCAL TAXES AND OTHER GOVERNMENT ASSESSMENTS; AND INSTALLATION CHARGES, EXCLUDING CAPITAL EXPENDITURES FOR PHYSICAL PLANT RENOVATION OR IN-WALL SHIELDING, WHICH SHOULD BE INCLUDED UNDER CONSTRUCTION COSTS OR INCORPORATED IN A FACILITY LEASE.

• FOR PROJECTS THAT INCLUDE NEW CONSTRUCTION, MODIFICATION, AND/OR RENOVATION; DOCUMENTATION MUST BE PROVIDED FROM A CONTRACTOR AND/OR ARCHITECT THAT SUPPORT THE ESTIMATED CONSTRUCTION COSTS.

The architect's letter supporting the construction cost estimate is provided in Attachment C, Economic Feasibility--1.

On the Project Costs Chart, following this response:

Line A.1, A&E fees, were estimated by the HCA Development Department.

Line A.2, legal, administrative, and consultant fees, include a contingency for expenses of an administrative appeals hearing.

Lines A.5 and A.6, construction cost and contingency, were estimated by the HCA Development Department. Contingency was estimated at approximately 5% of Tower area construction costs, and at approximately 8% of ED renovation and construction costs.

Line A.7 includes both fixed and moveable equipment costs, estimated by the HCA Development Department. The individual items costing $50,00 or more are:

• ED CT, workstation, injector	$730,300 including maintenance contract
• Definium 8000 Digital	$430,000
• Sonosite M-Turbo 1.3	$57,000 (there will be three of these)
• Proteus Tomorgraphy Unit	$94,000

Line A.9 includes:

• Preplanning, corporate staff	$175,000
• Information Systems/Telecomm.	$5,748,100
• Building fees	$937,000
• Testing	$456,000
• Environmental	$275,000

SUPPLEMENTAL #1
July 28, 2014
2:14 pm

PROJECT COSTS CHART -- CMC JOINT REPLACEMENT CENTER AND EMERGENCY DEPARTMENT (REVISED ON SUPPLEMENTAL)

A.	Construction and equipment acquired by purchase:		
1.	Architectural and Engineering Fees		$ 3,064,000
2.	Legal, Administrative, Consultant Fees (Excl CON Filing)		50,000
3.	Acquisition of Site		0
4.	Preparation of Site		2,615,000
5.	Construction Cost		51,800,000
6.	Contingency Fund		6,409,318
7.	Fixed Equipment (Not included in Construction)	In A.8	
8.	Moveable Equipment (List all equipment over $50,000)		20,601,893
9.	Other (Specify) I/S, telecomm, bldg fee, envir'l fees testing, HCA preplanning		7,591,100
B.	Acquisition by gift, donation, or lease:		
1.	Facility (inclusive of building and land)		0
2.	Building only		0
3.	Land only		0
4.	Equipment (Specify)		0
5.	Other (Specify)		0
C.	Financing Costs and Fees:		
1.	Interim Financing		4,015,696
2.	Underwriting Costs		0
3.	Reserve for One Year's Debt Service		0
4.	Other (Specify)		0
D.	Estimated Project Cost (A+B+C)		96,147,007
E.	CON Filing Fee		45,000
F.	Total Estimated Project Cost (D+E)	**TOTAL $**	96,192,007

Actual Capital Cost	96,192,007
Section B FMV	0

C(II).2. IDENTIFY THE FUNDING SOURCES FOR THIS PROJECT.

a. PLEASE CHECK THE APPLICABLE ITEM(S) BELOW AND BRIEFLY SUMMARIZE HOW THE PROJECT WILL BE FINANCED. (DOCUMENTATION FOR THE TYPE OF FUNDING MUST BE INSERTED AT THE END OF THE APPLICATION, IN THE CORRECT ALPHANUMERIC ORDER AND IDENTIFIED AS ATTACHMENT C, ECONOMIC FEASIBILITY--2).

_____A. Commercial Loan--Letter from lending institution or guarantor stating favorable initial contact, proposed loan amount, expected interest rates, anticipated term of the loan, and any restrictions or conditions;

_____B. Tax-Exempt Bonds--copy of preliminary resolution or a letter from the issuing authority, stating favorable contact and a conditional agreement from an underwriter or investment banker to proceed with the issuance;

_____C. General Obligation Bonds--Copy of resolution from issuing authority or minutes from the appropriate meeting;

_____D. Grants--Notification of Intent form for grant application or notice of grant award;

__x___E. Cash Reserves--Appropriate documentation from Chief Financial Officer; or

_____F. Other--Identify and document funding from all sources.

The project will be funded/financed by TriStar Centennial Medical Center's parent company, by means of a cash transfer through Centennial's Division office, TriStar Health System. Documentation of intent to fund the project is provided in Attachment C, Economic Feasibility--2.

C(II).3. DISCUSS AND DOCUMENT THE REASONABLENESS OF THE PROPOSED PROJECT COSTS. IF APPLICABLE, COMPARE THE COST PER SQUARE FOOT OF CONSTRUCTION TO SIMILAR PROJECTS RECENTLY APPROVED BY THE HSDA.

The justification of costs was provided in an earlier section, which is repeated here:

Table Three (Repeated): Average Construction Costs of Project			
	New Construction	**Renovation**	**Total Project**
Square Feet	84,123 SF	89,318 SF	173,441 SF
Construction Cost	$30,185,044	$21,614,956	$51,800,000
Constr. Cost PSF	$358.82 (rounded)	$242.00	$298.66 PSF

The estimated $51,800,000 cost of the project is approximately $298.66 per SF. The 2011-13 hospital construction projects approved by the HSDA had the following costs per SF. This project's construction cost is above the third quartile average cost of $274.63 per SF. It is relatively more expensive because of the need to stage the renovation and construction in phases in all the areas (emergency room; medical-surgical units) where patient care is being provided continuously.

Table Eight: Hospital Construction Cost Per Square Foot Applications Approved by the HSDA Years: 2011 – 2013			
	Renovation	**New Construction**	**Total Construction**
1st Quartile	$107.15/sq ft	$235.00/sq ft	$151.66/sq ft
Median	$179.00/sq ft	$274.63/sq ft	$227.88/sq ft
3rd Quartile	$249.00/sq ft	$324.00/sq ft	$274.63/sq ft

Source: Health Services and Development Agency website July 2014.

C(II).4. COMPLETE HISTORICAL AND PROJECTED DATA CHARTS ON THE FOLLOWING TWO PAGES--DO NOT MODIFY THE CHARTS PROVIDED OR SUBMIT CHART SUBSTITUTIONS. HISTORICAL DATA CHART REPRESENTS REVENUE AND EXPENSE INFORMATION FOR THE LAST THREE (3) YEARS FOR WHICH COMPLETE DATA IS AVAILABLE FOR THE INSTITUTION. PROJECTED DATA CHART REQUESTS INFORMATION FOR THE TWO YEARS FOLLOWING COMPLETION OF THIS PROPOSAL. PROJECTED DATA CHART SHOULD INCLUDE REVENUE AND EXPENSE PROJECTIONS FOR THE PROPOSAL ONLY (I.E., IF THE APPLICATION IS FOR ADDITIONAL BEDS, INCLUDE ANTICIPATED REVENUE FROM THE PROPOSED BEDS ONLY, NOT FROM ALL BEDS IN THE FACILITY).

See the following pages for these charts, with notes where applicable.

HISTORICAL DATA CHART – CENTENNIAL MEDICAL CENTER

Give information for the last three (3) years for which complete data are available for the facility or agency.
The fiscal year begins in January.

			Year 2011	Year 2012	Year 2013
		Discharges	23,187	25,830	28,064
A.	Utilization Data	Discharge Days	139,114	147,903	156,094
B.	Revenue from Services to Patients				
	1. Inpatient Services		$ 1,291,588,004	1,453,398,514	1,645,075,191
	2. Outpatient Services		661,222,347	727,818,802	838,009,511
	3. Emergency Services				
	4. Other Operating Revenue		3,847,766	3,290,353	3,567,942
	(Specify) See notes page				
		Gross Operating Revenue	$ 1,956,658,117	$ 2,184,507,669	$ 2,486,652,644
C.	Deductions for Operating Revenue				
	1. Contractual Adjustments		$ 1,455,033,022	1,622,745,285	1,904,669,517
	2. Provision for Charity Care		11,074,000	15,793,592	12,779,209
	3. Provisions for Bad Debt		20,104,098	38,456,235	20,818,765
		Total Deductions	$ 1,486,211,120	$ 1,676,995,112	$ 1,938,267,491
NET OPERATING REVENUE			$ 470,446,997	$ 507,512,557	$ 548,385,153
D.	Operating Expenses				
	1. Salaries and Wages		$ 168,173,275	181,584,775	189,576,980
	2. Physicians Salaries and Wages		0	0	0
	3. Supplies		98,419,185	105,524,675	115,665,749
	4. Taxes		4,224,820	4,162,334	4,587,374
	5. Depreciation		22,764,615	29,077,396	32,788,556
	6. Rent		7,697,526	7,733,537	7,447,826
	7. Interest, other than Capital		25,639,361	27,659,434	29,886,991
	8. Management Fees				
	a. Fees to Affiliates		32,122,341	29,700,924	35,523,447
	b. Fees to Non-Affiliates				
	9. Other Expenses (Specify)	See notes page	72,576,321	83,293,757	86,242,865
		Total Operating Expenses	$ 431,617,444	468,736,833	501,719,788
E.	Other Revenue (Expenses) -- Net (Specify)		$	$	$
NET OPERATING INCOME (LOSS)			$ 38,829,553	$ 38,775,724	$ 46,665,365
F.	Capital Expenditures				
	1. Retirement of Principal		$	$ 0	$
	2. Interest			0	
		Total Capital Expenditures	$ 0	$ 0	$ 0
NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES			$ 38,829,553	$ 38,775,724	$ 46,665,365

TriStar Centennial Medical Center
Historic Data Chart–Main Campus

D(9). Other Expenses:		Year 2011	Year 2012	Year 2013
Professional Services		5,090,231	8,410,230	10,787,460
Contract Services		44,442,590	49,669,279	49,426,462
Repairs and Maintenance		8,804,892	9,980,069	10,289,628
Utilities		5,686,794	5,933,888	6,019,013
Insurance		2,131,918	3,130,868	2,586,557
Investment Income		0	0	0
Interest income & sale of assets		(171,752)	(7,900)	(48,917)
Legal and Accounting Services		482,665	426,528	373,658
Marketing Expenses		2,535,616	1,943,078	2,372,242
Postage		601,343	675,344	802,432
Travel and Entertainment		1,213,023	1,294,399	1,176,948
Dues and Subscriptions		337,545	639,473	629,664
Education and Development		99,253	142,081	329,451
Recruiting		744,812	458,627	446,415
Licenses, permits and software		577,391	597,793	1,051,852
		72,576,321	83,293,757	86,242,865

PROJECTED DATA CHART– CENTENNIAL MEDICAL CENTER

Give information for the two (2) years following the completion of this proposal.

The fiscal year begins in January.

			CY 2016	CY 2017
		Discharges	34,216	36,448
A.	Utilization Data	Discharge Days	186,299	197,886
B.	Revenue from Services to Patients			
	1. Inpatient Services		$ 2,108,267,080	$ 2,214,928,446
	2. Outpatient Services		781,280,619	$ 889,783,069
	3. Emergency Services		172,786,773	$ 195,940,980
	4. Other Operating Revenue (Specify)	See notes page	3,603,621	$ 3,639,658
		Gross Operating Revenue	$ 3,065,938,093	$ 3,304,292,153
C.	Deductions for Operating Revenue			
	1. Contractual Adjustments		$ 2,349,795,263	$ 2,534,936,427
	2. Provision for Charity Care		16,363,923	$ 17,685,404
	3. Provisions for Bad Debt		27,488,472	$ 29,741,411
		Total Deductions	$ 2,393,647,658	$ 2,582,363,242
NET OPERATING REVENUE			$ 672,290,435	$ 721,928,911
D.	Operating Expenses			
	1. Salaries and Wages		$ 231,133,201	$ 248,439,861
	2. Physicians Salaries and Wages		0	$ 0
	3. Supplies		141,330,624	$ 150,797,155
	4. Taxes		5,581,068	$ 5,935,121
	5. Depreciation		36,247,775	$ 38,060,164
	6. Rent		8,985,832	$ 9,585,124
	7. Interest, other than Capital		36,639,829	$ 39,345,126
	8. Management Fees			
	a. Fees to Affiliates		43,999,706	$ 47,899,692
	b. Fees to Non-Affiliates		0	$ 0
	9. Other Expenses (Specify)	See notes page	105,144,035	$ 111,966,234
	Dues, Utilities, Insurance, and Prop Taxes.			
		Total Operating Expenses	$ 609,062,070	$ 652,028,477
E.	Other Revenue (Expenses) -- Net (Specify)		$	$
NET OPERATING INCOME (LOSS)			$ 63,228,366	$ 69,900,434
F.	Capital Expenditures			
	1. Retirement of Principal		$	$
	2. Interest			
		Total Capital Expenditures	$ 0	$ 0
NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES			$ 63,228,366	$ 69,900,434

TriStar Centennial Medical Center
Notes to Other Expenses
Projection Charts

D(9). Other Expenses:		2016	2017
		Main Facility	Main Facility
Professional Services		13,151,663	14,004,999
Contract Services		60,258,869	64,168,727
Repairs and Maintenance		12,544,725	13,358,681
Utilities		7,338,152	7,814,283
Insurance		3,153,433	3,358,041
Investment Income			
Interest income & sale of assets		(59,637)	(63,507)
Legal and Accounting Services		455,549	485,108
Marketing Expenses		2,892,148	3,079,802
Postage		978,295	1,041,770
Travel and Entertainment		1,434,891	1,527,992
Dues and Subscriptions		767,662	817,472
Education and Development		401,655	427,716
Recruiting		544,252	579,566
Licenses, permits and software		1,282,378	1,365,584
		105,144,035	111,966,234

TriStar Centennial Medical Center
Notes to Other Expenses
Projection Charts

D(9). Other Expenses:		2016	2017
		Proj ED	Proj ED
Professional Services		610,665	647,602
Contract Services		2,605,504	2,817,816
Repairs and Maintenance		529,243	598,444
Utilities		66,864	67,533
Insurance		0	0
Investment Income		0	0
Interest income & sale of assets		0	0
Legal and Accounting Services		42,706	45,737
Marketing Expenses		277,320	297,006
Postage		79,653	85,307
Travel and Entertainment		106,838	114,422
Dues and Subscriptions		57,172	61,230
Education and Development		51,300	54,942
Recruiting		38,443	41,172
Licenses, permits and software		79,366	85,000
		4,545,074	4,916,211

SUPPLEMENTAL #1
July 28, 2014
2:14 pm

PROJECTED DATA CHART-- CMC MAIN EMERGENCY DEPARTMENT (REVISED ON SUPPLEMENTAL)

Give information for the two (2) years following the completion of this proposal.
The fiscal year begins in January.

			CY 2016	CY 2017
A.	Utilization Data	ED Patients Presenting	40,711	42,746
B.	Revenue from Services to Patients			
	1. Inpatient Services		$ 0	$ 0
	2. Outpatient Services			
	3. Emergency Services		172,736,773	195,880,980
	4. Other Operating Revenue (Specify)	See notes page		
		Gross Operating Revenue	$ 172,736,773	$ 195,880,980
C.	Deductions for Operating Revenue			
	1. Contractual Adjustments		$ 116,924,842	$ 134,091,595
	2. Provision for Charity Care		4,081,196	4,633,434
	3. Provisions for Bad Debt		23,126,780	26,256,125
		Total Deductions	$ 144,132,818	$ 164,981,154
NET OPERATING REVENUE			$ 28,603,955	$ 30,899,826
D.	Operating Expenses			
	1. Salaries and Wages		$ 7,821,893	$ 8,134,136
	2. Physicians Salaries and Wages		0	0
	3. Supplies		2,361,238	2,553,646
	4. Taxes		94,644	95,157
	5. Depreciation		970,754	980,462
	6. Rent		569,954	610,413
	7. Interest, other than Capital		1,558,916	1,684,041
	8. Management Fees			
	a. Fees to Affiliates		2,467,657	2,798,287
	b. Fees to Non-Affiliates			
	9. Other Expenses (Specify)	See notes page	4,545,074	4,916,211
	Dues, Utilities, Insurance, and Prop Taxes.			
		Total Operating Expenses	$ 20,390,130	$ 21,772,351
E.	Other Revenue (Expenses) -- Net (Specify)		$	$
NET OPERATING INCOME (LOSS)			$ 8,213,825	$ 9,127,475
F.	Capital Expenditures			
	1. Retirement of Principal		$	$
	2. Interest			
		Total Capital Expenditures	$ 0	$ 0
NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES			$ 8,213,825	$ 9,127,475

SUPPLEMENTAL #1
July 28, 2014
2:14 pm

PROJECTED DATA CHART--JOINT REPLACEMENT CENTER OF EXCELLENCE
(INCLUDES OPERATING SUITE, 29 BEDS, ALL SERVICES WITHIN THE UNIT)
(REVISED ON SUPPLEMENTAL)

Give information for the two (2) years following the completion of this proposal.

The fiscal year begins in January.

			CY2016	CY2017
		Discharges	2869	2999
A.	Utilization Data	Discharge Days	8,606	8,997
B.	Revenue from Services to Patients			
	1. Inpatient Services		$ 290,724,836	$ 328,209,999
	2. Outpatient Services			
	3. Emergency Services		0	0
	4. Other Operating Revenue (Specify)	See notes page		
		Gross Operating Revenue	$ 290,724,836	$ 328,209,999
C.	Deductions for Operating Revenue			
	1. Contractual Adjustments		$ 226,587,269	$ 260,898,802
	2. Provision for Charity Care		472,979	534,525
	3. Provisions for Bad Debt		2,680,212	3,028,974
		Total Deductions	$ 229,740,460	$ 264,462,301
NET OPERATING REVENUE			$ 60,984,376	$ 63,747,698
D.	Operating Expenses			
	1. Salaries and Wages		$ 20,352,121	$ 21,178,598
	2. Physicians Salaries and Wages		0	0
	3. Supplies		19,113,393	20,578,842
	4. Taxes		667,359	636,173
	5. Depreciation		4,639,415	4,685,809
	6. Rent		588,300	605,949
	7. Interest, other than Capital		3,323,648	3,474,250
	8. Management Fees			
	a. Fees to Affiliates		4,153,193	4,688,693
	b. Fees to Non-Affiliates			
	9. Other Expenses (Specify)	See notes page	6,758,299	6,971,060
	Dues, Utilities, Insurance, and Prop Taxes.			
		Total Operating Expenses	$ 59,595,728	$ 62,819,374
E.	Other Revenue (Expenses) -- Net (Specify)		$	$
NET OPERATING INCOME (LOSS)			$ 1,388,648	$ 928,324
F.	Capital Expenditures			
	1. Retirement of Principal		$	$
	2. Interest			
		Total Capital Expenditures	$ 0	$ 0
NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES			$ 1,388,648	$ 928,324

TriStar Centennial Medical Center
Notes to Other Expenses
Projection Charts

D(9). Other Expenses:		2016	2017
		Proj Joint	Proj Joint
Professional Services		825,385	850,147
Contract Services		3,817,340	3,931,860
Repairs and Maintenance		851,672	877,222
Utilities		484,856	499,402
Insurance		214,538	230,987
Investment Income		0	0
Interest income & sale of assets		0	0
Legal and Accounting Services		32,898	33,885
Marketing Expenses		213,632	220,041
Postage		61,361	63,201
Travel and Entertainment		82,302	84,771
Dues and Subscriptions		44,042	45,363
Education and Development		39,519	40,705
Recruiting		29,615	30,503
Licenses, permits and software		61,139	62,973
		6,758,299	6,971,060

C(II).5. PLEASE IDENTIFY THE PROJECT'S AVERAGE GROSS CHARGE, AVERAGE DEDUCTION FROM OPERATING REVENUE, AND AVERAGE NET CHARGE.

Table Seventeen-A : Average Charges, Deductions, Net Charges and Income Emergency Department		
	CY2016	**CY2017**
ED Visits, all Levels of Acuity	40,711	42,746
Average Gross Charge Per Visit	$4,243	$4,582
Average Deduction Per Visit	$3,540	$3,860
Average Net Charge (Net Operating Revenue) Per Visit	$703	$723
Average Net Operating Income Per Visit After Capital Expenditures	$202	$214

Table Seventeen-B: Average Charges, Deductions, Net Charges and Income Joint Replacement Center of Excellence Surgical Department and 29-Bed Specialty Unit		
	CY2016	**CY2017**
Discharge Days	8,606	8,997
Discharges	2,869	2,999
Average Gross Charge Per Day	$33,872	$36,480
Average Gross Charge Per Discharge	$101,333	$109,440
Average Deduction from Operating Revenue per Day	$26,695	$29,394
Average Deduction from Operating Revenue per Discharge	$80,077	$88,183
Average Net Charge (Net Operating Revenue) Per Day	$7,086	$7,085
Average Net Charge (Net Operating Revenue) Per Discharge	$21,256	$21,256
Average Net Operating Income after Expenses, Per Day	$161	$103
Average Net Operating Income after Expenses, Per Discharge	$484	$310

C(II).6.A. PLEASE PROVIDE THE CURRENT AND PROPOSED CHARGE SCHEDULES FOR THE PROPOSAL. DISCUSS ANY ADJUSTMENT TO CURRENT CHARGES THAT WILL RESULT FROM THE IMPLEMENTATION OF THE PROPOSAL. ADDITIONALLY, DESCRIBE THE ANTICIPATED REVENUE FROM THE PROPOSED PROJECT AND THE IMPACT ON EXISTING PATIENT CHARGES.

The project's most frequent charges for medical-surgical admissions are shown in response to C(II).6.B below. The construction of the proposed beds and operating rooms will not affect any hospital charges. Medical-surgical departments and their associated operating rooms operate with a positive revenue margin, making it unnecessary to shift costs to other hospital services. The ED, which is only a renovation project, would not require adjustment of the applicant's charge structures.

C(II).6.B. COMPARE THE PROPOSED CHARGES TO THOSE OF SIMILAR FACILITIES IN THE SERVICE AREA/ADJOINING SERVICE AREAS, OR TO PROPOSED CHARGES OF PROJECTS RECENTLY APPROVED BY THE HSDA. IF APPLICABLE, COMPARE THE PROJECTED CHARGES OF THE PROJECT TO THE CURRENT MEDICARE ALLOWABLE FEE SCHEDULE BY COMMON PROCEDURE TERMINOLOGY (CPT) CODE(S).

There is no publicly available data that enable the applicant's Emergency Department or Orthopedic Surgery programs to be compared to those of other hospitals in the service area. Table Eighteen-A on the following page compares the service area hospitals' total gross charges (revenues) per admission and per day.

Table Eighteen-B on the second following page shows the most frequent types of Skyline's medical-surgical and Joint Replacement Center admissions, with their current Medicare reimbursement, and their projected Years One and Two utilization and average gross charges. Table 18-C provides similar information for the Emergency Department.

Table Eighteen-A (Clarification): Comparative Gross Charges for General Acute Care Hospitals in the Primary Service Area 2013 (Column Titles Clarified)							
	2013 Joint Annual Reports of Hospitals						
State ID	Facility Name	County	Total Gross IP Revenues*	Admissions or Discharges	Days	Total Gross IP Revenues* Per IP Admission	Total Gross IP Revenues* Per IP Day
	TriStar Ashland City Medical Center	Cheatham	$5,349,537	197	1,397	$27,155.01	$3,829.30
	Metro Nashville General Hospital	Davidson	$91,779,694	3,517	16,088	$26,096.02	$5,704.85
	Saint Thomas Midtown Hospital (Baptist)	Davidson	$823,839,816	24,105	110,408	$34,177.13	$7,461.78
	Saint Thomas West Hospital	Davidson	$1,043,595,140	21,386	99,877	$48,798.05	$10,448.80
	TriStar Centennial Medical Center	Davidson	$1,633,843,746	28,064	156,094	$58,218.49	$10,467.05
	TriStar Skyline Medical Center	Davidson	$627,266,730	10,024	55,811	$62,576.49	$11,239.12
	TriStar Southern Hills Medical Center	Davidson	$199,471,821	4,209	20,068	$47,391.74	$9,939.80
	TriStar Summit Medical Center	Davidson	$466,903,878	10,636	43,122	$43,898.45	$10,827.51
	Vanderbilt Medical Center	Davidson	$3,105,554,497	53,957	298,505	$57,556.10	$10,403.69
	Gateway Medical Center	Montgomery	$380,471,988	9,804	36,609	$38,807.83	$10,392.85
	Northcrest Medical Center	Robertson	$64,371,507	3,230	13,916	$19,929.26	$4,625.72
	Saint Thomas Rutherford Hospital	Rutherford	$433,934,096	16,176	63,503	$26,825.80	$6,833.28
	TriStar Stonecrest Medical Center	Rutherford	$158,132,676	5,124	16,254	$30,861.18	$9,728.85
	Sumner Regional Medical Center	Sumner	$241,154,622	7,529	32,682	$32,030.10	$7,378.82
	TriStar Hendersonville Medical Center	Sumner	$241,043,436	5,828	20,567	$41,359.55	$11,719.91
	Williamson Medical Center	Williamson	$188,211,011	7,981	30,171	$23,582.38	$6,238.14
	University Medical Center (UMC)	Wilson	$242,117,405	5,080	22,423	$47,660.91	$10,797.73
	SERVICE AREA TOTALS		**$9,947,041,600**	**216,847**	**1,037,495**	**$45,871.24**	**$9,587.56**

Source: Joint Annual Reports p. 18, inpatient gross charges excluding newborns.
Note Saint Thomas Hospital for Spinal Surgery did not report yet (7-11/14) and is excluded.

Table Eighteen-B: Centennial Medical Center Most Frequent DRG's						
				Average Gross Charge		
DRG's	Descriptor	Cases	Medicare Reimbursement	Current	Year 1	Year 2
	Medical-Surgical Department					
871	Septi/Seps W/O Mv96+Hr W/ MCC	1,363	$ 11,571	$ 76,619	76,619	76,619
236	Corn Bypass W/O Cath W/O MCC	1,343	$ 22,026	$ 149,228	149,228	149,228
470	Maj Join Rep/Reat Le W/O M	1,189	$ 13,196	$ 64,232	64,232	64,232
219	Cv & Px W/O C Cath W/ MCC	795	$ 54,280	$ 331,137	331,137	331,137
292	Heart Fail/Shock W/ CC	777	$ 6,314	$ 42,770	42,770	42,770
853	Inf & Par Dis Or Px W/ MCC	752	$ 191,360	$ 268,079	268,079	268,079
235	Corn Bypass W/O Cath W/ MCC	748	$ 32,816	$ 189,449	189,449	189,449
460	Spnal Fusn X Cervcal W/O MCC	679	$ 23,447	$ 77,422	77,422	77,422
287	Circ Dis No Mi Wcath W/O MCC	600	$ 6,562	$ 54,498	54,498	54,498
291	Heart Fail/Shock W/ MCC	569	$ 11,337	$ 66,682	66,682	66,682
	Joint Replacement Center of Excellence					
470	Maj Join Rep/Reat Le W/O M	413	$ 13,196	$ 64,232	$ 64,232	$ 64,232
462	Bil/Mult M/Jont Le W/O MCC	39	$ 20,460	$ 86,794	$ 86,794	$ 86,794
468	Rev Hip/Kne Repl W/O CC/MCC	32	$ 16,785	$ 83,944	$ 83,944	$ 83,944
484	Maj Reatt Px Up Ext W/O CC	31	$ 13,446	$ 66,418	$ 66,418	$ 66,418
494	Le & Hum Px W/O CC/MCC	22	$ 8,477	$ 58,609	$ 58,609	$ 58,609
481	Hip/Femur Px X Mj W/ CC	20	$ 12,765	$ 67,302	$ 67,302	$ 67,302
482	Hip/Femur Px X Mj W/O CC	18	$ 9,992	$ 60,032	$ 60,032	$ 60,032
483	Maj Reatt Px Up Ext CC/MCC	17	$ 16,175	$ 80,794	$ 80,794	$ 80,794
467	Rev Hip/Knee Repl W/ CC	16	$ 18,514	$ 103,137	$ 103,137	$ 103,137
563	Fx Spn Stn Dis Ex Le W/O MCC	15	$ 4,944	$ 19,221	$ 19,221	$ 19,221

Source: Hospital management.

Table Eighteen-C: Centennial Medical Center
Main Hospital Emergency Department Charges By Level of Care

SERVICE LEVEL	CPT CODE	2014 CURRENT CHARGE	CURRENT 2014 MEDICARE REIMBURSEMENT	2015 PROJECTED CHARGE	YEAR ONE 2016 PROJECTED CHARGE	YEAR TWO 2017 PROJECTED CHARGE
LEVEL ONE	99281	$201.18	$51.62	$201.18	$201.18	$201.18
LEVEL TWO	99282	$343.03	$93.58	$343.03	$343.03	$343.03
LEVEL THREE	99283	$729.19	$154.35	$729.19	$729.19	$729.19
LEVEL FOUR	99284	$1,304.27	$272.35	$1,304.27	$1,304.27	$1,304.27
LEVEL FIVE	99285	$1,698.55	$422.77	$1,698.55	$1,698.55	$1,698.55

C(II).7. DISCUSS HOW PROJECTED UTILIZATION RATES WILL BE SUFFICIENT TO MAINTAIN COST-EFFECTIVENESS.

These are not new services for Centennial Medical Center; they are enhancements to the patient experience and the operating efficiency of existing programs (joint replacement and emergency services). The services are already cost-effective and are part of an overall hospital financial structure that operates with a positive margin. Utilization projections in prior sections of the application indicate that the improved areas will remain highly utilized and will continue to contribute to a positive operating margin.

C(II).8. DISCUSS HOW FINANCIAL VIABILITY WILL BE ENSURED WITHIN TWO YEARS; AND DEMONSTRATE THE AVAILABILITY OF SUFFICIENT CASH FLOW UNTIL FINANCIAL VIABILITY IS MAINTAINED.

These are not new services; this is a facility that already has positive cash flow and the Projected Data Charts for the project's components indicate continuing positive cash flow.

C(II).9. DISCUSS THE PROJECT'S PARTICIPATION IN STATE AND FEDERAL REVENUE PROGRAMS, INCLUDING A DESCRIPTION OF THE EXTENT TO WHICH MEDICARE, TENNCARE/MEDICAID, AND MEDICALLY INDIGENT PATIENTS WILL BE SERVED BY THE PROJECT. IN ADDITION, REPORT THE ESTIMATED DOLLAR AMOUNT OF REVENUE AND PERCENTAGE OF TOTAL PROJECT REVENUE ANTICIPATED FROM EACH OF TENNCARE, MEDICARE, OR OTHER STATE AND FEDERAL SOURCES FOR THE PROPOSAL'S FIRST YEAR OF OPERATION.

Table Nineteen: Medicare and TennCare/Medicaid Revenues, Year One		
Emergency Department		
	Medicare	**TennCare/Medicaid**
Gross Revenue	$38,002,090	$57,003,135
Percent of Gross Revenue	22%	33%
Joint Replacement Program		
	Medicare	**TennCare/Medicaid**
Gross Revenue	$165,713,157	$20,350,739
Percent of Gross Revenue	57%	7%

C(II).10. PROVIDE COPIES OF THE BALANCE SHEET AND INCOME STATEMENT FROM THE MOST RECENT REPORTING PERIOD OF THE INSTITUTION, AND THE MOST RECENT AUDITED FINANCIAL STATEMENTS WITH ACCOMPANYING NOTES, IF APPLICABLE. FOR NEW PROJECTS, PROVIDE FINANCIAL INFORMATION FOR THE CORPORATION, PARTNERSHIP, OR PRINCIPAL PARTIES INVOLVED WITH THE PROJECT. COPIES MUST BE INSERTED AT THE END OF THE APPLICATION, IN THE CORRECT ALPHANUMERIC ORDER AND LABELED AS ATTACHMENT C, ECONOMIC FEASIBILITY--10.

These are provided as Attachment C, Economic Feasibility--10.

C(II)11. DESCRIBE ALL ALTERNATIVES TO THIS PROJECT WHICH WERE CONSIDERED AND DISCUSS THE ADVANTAGES AND DISADVANTAGES OF EACH ALTERNATIVE, INCLUDING BUT NOT LIMITED TO:

A. A DISCUSSSION REGARDING THE AVAILABILITY OF LESS COSTLY, MORE EFFECTIVE, AND/OR MORE EFFICIENT ALTERNATIVE METHODS OF PROVIDING THE BENEFITS INTENDED BY THE PROPOSAL. IF DEVELOPMENT OF SUCH ALTERNATIVES IS NOT PRACTICABLE, THE APPLICANT SHOULD JUSTIFY WHY NOT, INCLUDING REASONS AS TO WHY THEY WERE REJECTED.

B. THE APPLICANT SHOULD DOCUMENT THAT CONSIDERATION HAS BEEN GIVEN TO ALTERNATIVES TO NEW CONSTRUCTION, E.G., MODERNIZATION OR SHARING ARRANGEMENTS. IT SHOULD BE DOCUMENTED THAT SUPERIOR ALTERNATIVES HAVE BEEN IMPLEMENTED TO THE MAXIMUM EXTENT PRACTICABLE.

The creation of additional surgical capacity and a specialty medical-surgical unit for joint replacement patients is necessary to respond to the needs of new additions to the medical staff in CY2015, who will soon more than double this type of case volume at Centennial. The hospital's medical-surgical units are too full to accommodate this level of growth without expanding licensed capacity. Because they are physicians who are deeply committed to improving the quality and efficiency of this specialty, it is necessary to create an integrated physical setting where they staff colleagues can pursue excellence and cost-effectiveness in their work.

The main hospital building at Centennial is highly utilized in its medical-surgical nursing units, and has no vacant space capable of accommodating an integrated Joint Replacement program with the comprehensive continuum of care that is being proposed. The project does make use of all existing shelled space on the 7th floor; as well as existing patient care space existing on the eighth floor. However, a lateral expansion with new construction is necessary on the 8th floor to create a Joint Replacement surgical area connected to staging and recovery, and vertical new construction of a new 9th floor is needed to replace the 36 general medical-surgical beds being displaced from the 8th floor.

C(III).1. LIST ALL EXISTING HEALTH CARE PROVIDERS (I.E., HOSPITALS, NURSING HOMES, HOME CARE ORGANIZATIONS, ETC.) MANAGED CARE ORGANIZATIONS, ALLIANCES, AND/OR NETWORKS WITH WHICH THE APPLICANT CURRENTLY HAS OR PLANS TO HAVE CONTRACTUAL AND/OR WORKING RELATIONSHIPS, E.G., TRANSFER AGREEMENTS, CONTRACTUAL AGREEMENTS FOR HEALTH SERVICES.

As a tertiary referral hospital serving eight counties with a CY2018 population that will approach two million residents, TriStar Centennial regularly discharges patients to more than a hundred Middle Tennessee and Kentucky nursing homes, home health agencies, hospices, and rehabilitation hospitals and units of hospitals. It is the central tertiary facility for HCA's TriStar Health System, HCA's Tennessee and Kentucky hospital division.

C(III).2. DESCRIBE THE POSITIVE AND/OR NEGATIVE EFFECTS OF THE PROPOSAL ON THE HEALTH CARE SYSTEM. PLEASE BE SURE TO DISCUSS ANY INSTANCES OF DUPLICATION OR COMPETITION ARISING FROM YOUR PROPOSAL, INCLUDING A DESCRIPTION OF THE EFFECT THE PROPOSAL WILL HAVE ON THE UTILIZATION RATES OF EXISTING PROVIDERS IN THE SERVICE AREA OF THE PROJECT.

The project will have only positive impacts on the community. It will give patients and emergency services personnel a significantly improved, more specialized, and more efficient physical environment for emergency care. It will provide an expanding orthopedic medical staff and hospital staff with an optimal, complete, and self-contained continuum of care for the joint replacement patients and their families. It will offer service consolidations that can be managed to produce the best clinical outcomes at the most cost-efficient level of operation, in one integrated physical environment. It will minimize new construction and require only a minor incremental addition of licensed bed capacity to the service area; and that capacity will be added at a tertiary referral facility whose medical-surgical bed utilization is already very high on an annual basis, and exceptionally high mid-week.

This project responds to the needs of surgeons who are already practicing at Centennial Medical Center or have decided to relocate cases to Centennial in CY 2015. The pending 1,500-case relocation of SJRI patients to Centennial will obviously reduce cases temporarily at their current hospital. However, that loss likely will be of short duration, as that facility continues to develop its own orthopedic and sports management programs. The surging demand nationally for joint replacements in an aging population should provide sufficient demand in this region for both these hospitals to implement and to efficiently utilize integrated inpatient Centers of Excellence such as this--which is an appropriate and optimal way to manage care processes for this particular type of patient.

C(III).3. PROVIDE THE CURRENT AND/OR ANTICIPATED STAFFING PATTERN FOR ALL EMPLOYEES PROVIDING PATIENT CARE FOR THE PROJECT. THIS CAN BE REPORTED USING FTE'S FOR THESE POSITIONS. IN ADDITION, PLEASE COMPARE THE CLINICAL STAFF SALARIES IN THE PROPOSAL TO PREVAILING WAGE PATTERNS IN THE SERVICE AREA AS PUBLISHED BY THE TENNESSEE DEPARTMENT OF LABOR & WORKFORCE DEVELOPMENT AND/OR OTHER DOCUMENTED SOURCES.

The Department of Labor and Workforce Development website indicates the following annual salary information for clinical employees of this project, in the Nashville area:

Table Twenty-A: TDOL Surveyed Average Salaries for the Region (2013)				
Position	Entry Level	Mean	Median	Experienced
RN	$44,710	$58,260	$58,060	$65,040
Phlebotomist	$19,610	$27,170	$27,360	$30,950
Pharmacist	$90,670	$118,710	$119,480	$132,730
Physical Therapist	$55,920	$73,260	$73,720	$81,940
Occupat'l Therapist	$61,570	$74,180	$74,190	$80,480
Social Worker	$23,210	$42,320	$41,680	$51,870

Source: TN Dept of Labor and Workforce Development, 2013 Surveys.

Please see Table Twenty-B on the following page for a chart of projected FTE's and salary ranges.

Table Twenty-B: Centennial Medical Center Current and Projected Staffing--Patient Care Positions Emergency and Medical-Surgical Departments				
Position Type (RN, etc.)	Current FTE's	Year One FTE's	Year Two FTE's	Annual Salary Range
MAIN EMERGENCY DEPARTMENT				
RN	33.450	42.250	52.55	$50,000 - $80,000
Paramedic	3.660	3.660	5.66	$30,000 - $50,000
MAIN HOSPITAL MED/SURG DEPARTMENT				
RN	286.090	330.815	337.431	$50,000 - $80,000
Nurse Navigator	0.000	4.000	4.080	$40,000 - $60,000
Patient Care Tech	0.000	21.000	21.420	$25,000 - $35,000
Surgery Attendant	6.000	8.000	8.160	$70,000 - $100,000
Holding Nurse	3.000	4.000	4.080	$25,000 - $35,000
Anesthesia Tech	5.000	6.000	6.120	$25,000 - $40,000
Central Sterile Tech	13.000	25.000	25.500	$25,000 - $40,000
Phlebotomist	1.000	4.000	4.080	$25,000 - $45,000
Pre-Admission Testing RN	5.900	6.800	6.936	$30,000 - $50,000
Pharmacist	38.320	39.320	40.106	$90,000 - $130,000
Pharmacist Tech	26.340	27.340	27.887	$30,000 - $70,000
Medical Technologist	11.000	13.100	13.362	$40,000 - $70,000
Lab Phlebotomist	25.100	26.100	26.622	$25,000 - $45,000
Radiology Tech	30.800	33.800	34.476	$40,000 - $70,000
Physical Therapist	16.752	20.752	21.167	$60,000 - $90,000
Occupational Therapist	6.924	7.924	8.082	$60,000 - $80,000
FNS Utility Asst	25.500	26.500	27.030	$20,000 - $35,000
Diet Clerk	6.000	7.000	7.140	$30,000 - $40,000
Transporter	24.000	26.000	26.520	$20,000 - $35,000
Employee Health Nurse	1.000	1.500	1.530	$30,000 - $50,000
Social Worker	9.000	10.000	10.200	$40,000 - $60,000
Utilization Review Nurse	7.000	8.000	8.160	$60,000 - $80,000
Total FTE's	584.84	702.86	728.30	

Source: Hospital management. Excludes Women's Hospital and Spring Hill facilities operated under CMC license.

C(III).4. DISCUSS THE AVAILABILITY OF AND ACCESSIBILITY TO HUMAN RESOURCES REQUIRED BY THE PROPOSAL, INCLUDING ADEQUATE PROFESSIONAL STAFF, AS PER THE DEPARTMENT OF HEALTH, THE DEPARTMENT OF MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES, AND/OR THE DIVISION OF MENTAL RETARDATION SERVICES LICENSING REQUIREMENTS.

TriStar Centennial Medical Center anticipates no difficulties in attracting the additional staff needed to operate the expanded services proposed in this project.

C(III).5. VERIFY THAT THE APPLICANT HAS REVIEWED AND UNDERSTANDS THE LICENSING CERTIFICATION AS REQUIRED BY THE STATE OF TENNESSEE FOR MEDICAL/CLINICAL STAFF. THESE INCLUDE, WITHOUT LIMITATION, REGULATIONS CONCERNING PHYSICIAN SUPERVISION, CREDENTIALING, ADMISSIONS PRIVILEGES, QUALITY ASSURANCE POLICIES AND PROGRAMS, UTILIZATION REVIEW PPOLICIES AND PROGRAMS, RECORD KEEPING, AND STAFF EDUCATION.

The applicant so verifies.

C(III).6. DISCUSS YOUR HEALTH CARE INSTITUTION'S PARTICIPATION IN THE TRAINING OF STUDENTS IN THE AREAS OF MEDICINE, NURSING, SOCIAL WORK, ETC. (I.E., INTERNSHIPS, RESIDENCIES, ETC.).

Centennial Medical Center has approximately 78 contractual relationships with health professions training programs in this region. Please see the list on the following page.

CMC TRAINING AFFILIATE	TYPE OF CONTRACT	DEPARTMENT	DESCRIPTION
University of Tennessee at Memphis	Clinical Affiliation Agreement	Pharmacy	
Trevecca Nazarene University	Affiliation Agreement	Medical Staff-Support Svc	Physician Assistant
Meharry Medical College	Clinical Affiliation Agreement	Parthenon Pavilion	
Meharry Medical College	Clinical Affiliation Agreement	Women's Hospital	
Kettering College of Medical Arts	Affiliation Agreement	Medical Staff-Support Svc	
Lincoln Memorial University	Educational Agreements	Medical Staff-Support Svc	Physician-Assistant Program
Wayne State University	Clinical Affiliation Agreement	Physical Therapy	
Belmont University	Educational Agreements	Physical Therapy	Physical Therapy
Union University	Affiliation Agreement	Nursing	
Wake Forest School of Medicine	Clinical Affiliation Agreement	Medical Staff-Support Svc	Physician Asst. Clinical Affiliation
MedVance Institute	Affiliation Agreement	Laboratory Services	
Lipscomb University	Clinical Affiliation Agreement	Pharmacy	Pharmacy - Student Preceptor
Columbia State Community College	Affiliation Agreement	Nursing	
Brandman University	Affiliation Agreement	Parthenon Pavilion	
Lincoln Memorial University	Affiliation Agreement	Medical Staff-Support Svc	
Nashville State Community College	Affiliation Agreement	Surgery	Central Processing Technology Program
University of Tennessee at Chattanooga	Affiliation Agreement	Physical Therapy	
Lipscomb University	Educational Agreements	Dietary Services	
Middle Tennessee State University	Educational Agreements	Nursing	Nursing - Educational Agreement
Nashville State Technical Community College	Educational Agreements	Surgery	
Vanderbilt University	Educational Agreements	Rehab Services	
Vanderbilt University	Educational Agreements	Nursing	Nursing
Volunteer State Community College	Educational Agreements	Education	
Tennessee State University	Educational Agreements	Rehab Services	PT & OT
AUSTIN PEAY STATE UNIVERSITY	Educational Agreements	Nursing	
Belmont University	Educational Agreements	Nursing	Education Agreement - Nursing
AUSTIN PEAY STATE UNIVERSITY	Educational Agreements	Education	Radiologic Technology, Clinical Students
Tennessee Tech University	Educational Agreements	Dietary Services	
University of Tennessee at Memphis	Educational Agreements	Laboratory Services	Medical Technology
AUSTIN PEAY STATE UNIVERSITY	Educational Agreements	Education	Medical Technology / Medical
University of Tennessee	Educational Agreements	Social Services	Social Work
Fortis Institute	Educational Agreements	Medical Imaging	Radiologic Technology
American Society of Health-System Pharmacists	Educational Agreements	Pharmacy	
University of Tennessee at Martin	Educational Agreements	Dietary Services	
Madisonville Community College	Educational Agreements	Education	
Cheatham County Schools	Educational Agreements	Administration	
University of Tennessee	Educational Agreements	Parthenon Pavilion	
AUSTIN PEAY STATE UNIVERSITY	Educational Agreements	Oncology	
Middle Tennessee State University	Educational Agreements	Parthenon Pavilion	
Lipscomb University	Educational Agreements	Education	School of Nursing
University of Alabama	Educational Agreements	Education	Graduate & Undergraduate Education
Vanderbilt University	Educational Agreements	Education	
Fortis Institute	Educational Agreements	Surgery	
Brecklnridge School of Nursing at ITT Technical Institute	Educational Agreements	Nursing	
Argosy University Twin Cities	Educational Agreements	Medical Imaging	CV Sonography
Middle Tennessee State University	Educational Agreements	Case Management	
A. T. Still University	Educational Agreements	Rehab Services	
Marywood University	Educational Agreements	Dietary Services	
Walden University	Educational Agreements	Nursing	
Tennessee Technology Center at Nashville	Educational Agreements	Laboratory Services	
Angelo State University	Educational Agreements	Education	Post Masters - Registered Nurst First
Meharry Medical College	Educational Agreements	Medical Staff-Support Svc	Resident Medical Education
A. T. Still University	Educational Agreements	Medical Staff-Support Svc	Medical School Program
University of Mississippi Medical Center	Educational Agreements	Physical Therapy	Physical Therapy
University of Missouri	Educational Agreements	Women's Hospital	Internship - Child Life Specialist
Mississippi State University	Educational Agreements	Women's Hospital	
Fortis Institute	Educational Agreements	Laboratory Services	MLT
University of Alabama Birmingham	Educational Agreements	Education	
University of Missouri	Educational Agreements	Nursing	
Weber State University	Educational Agreements	Education	
University of Houston	Educational Agreements	Dietary Services	
University of Cincinnati	Educational Agreements	Laboratory Services	
Fortis Institute	Educational Agreements	Nursing	
Meharry Medical College School of Medicine	Educational Agreements	Education	
Nashville State Community College	Educational Agreements	Nursing	
Norwich University	Educational Agreements	Nursing	
Middle Tennessee School of Anesthesia	Educational Agreements	Nursing	CRNA Program
Meharry Medical College	Educational Agreements	Education	Surgery Program
Bethel University	Educational Agreements	Education	Physician's Asst. Program
Meharry Medical College	Educational Agreements	Medical Staff-Support Svc	Residency
Thomas Edison State College	Educational Agreements	Nursing	Nursing
University of Tennessee Emergency Medicine Residency Program	Program Agreement	Administration	
Emory University	Educational Agreements	Education	
Tennessee Board of Regents	Educational Agreements	Education	
Western Kentucky University	Educational Agreements	Education	College of Health and Human Services
Aquinas College	Educational Agreements	Education	Nursing
Belmont University	Educational Agreements	Parthenon Pavilion	Pastoral Care
Cumberland University	Educational Agreements	Nursing	

C(III).7(a). PLEASE VERIFY, AS APPLICABLE, THAT THE APPLICANT HAS REVIEWED AND UNDERSTANDS THE LICENSURE REQUIREMENTS OF THE DEPARTMENT OF HEALTH, THE DEPARTMENT OF MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES, THE DIVISION OF MENTAL RETARDATION SERVICES, AND/OR ANY APPLICABLE MEDICARE REQUIREMENTS.

The applicant so verifies.

C(III).7(b). PROVIDE THE NAME OF THE ENTITY FROM WHICH THE APPLICANT HAS RECEIVED OR WILL RECEIVE LICENSURE, CERTIFICATION, AND/OR ACCREDITATION

LICENSURE:	Board for Licensure of Healthcare Facilities Tennessee Department of Health
CERTIFICATION:	Medicare Certification from CMS TennCare Certification from TDH
ACCREDITATION:	Joint Commission

C(III).7(c). IF AN EXISTING INSTITUTION, PLEASE DESCRIBE THE CURRENT STANDING WITH ANY LICENSING, CERTIFYING, OR ACCREDITING AGENCY OR AGENCY.

The applicant is currently licensed in good standing by the Board for Licensing Health Care Facilities, certified for participation in Medicare and Medicaid/TennCare, and fully accredited by the Joint Commission on Accreditation of Healthcare Organizations.

C(III).7(d). FOR EXISTING LICENSED PROVIDERS, DOCUMENT THAT ALL DEFICIENCIES (IF ANY) CITED IN THE LAST LICENSURE CERTIFICATION AND INSPECTION HAVE BEEN ADDRESSED THROUGH AN APPROVED PLAN OF CORRECTION. PLEASE INCLUDE A COPY OF THE MOST RECENT LICENSURE/CERTIFICATION INSPECTION WITH AN APPROVED PLAN OF CORRECTION.

They have been addressed. A copy of the most recent licensure inspection and plan of correction, and/or the most recent accreditation inspection, are provided in Attachment C, Orderly Development--7(C).

C(III)8. DOCUMENT AND EXPLAIN ANY FINAL ORDERS OR JUDGMENTS ENTERED IN ANY STATE OR COUNTRY BY A LICENSING AGENCY OR COURT AGAINST PROFESSIONAL LICENSES HELD BY THE APPLICANT OR ANY ENTITIES OR PERSONS WITH MORE THAN A 5% OWNERSHIP INTEREST IN THE APPLICANT. SUCH INFORMATION IS TO BE PROVIDED FOR LICENSES REGARDLESS OF WHETHER SUCH LICENSE IS CURRENTLY HELD.

None.

C(III)9. IDENTIFY AND EXPLAIN ANY FINAL CIVIL OR CRIMINAL JUDGMENTS FOR FRAUD OR THEFT AGAINST ANY PERSON OR ENTITY WITH MORE THAN A 5% OWNERSHIP INTEREST IN THE PROJECT.

None.

C(III)10. IF THE PROPOSAL IS APPROVED, PLEASE DISCUSS WHETHER THE APPLICANT WILL PROVIDE THE THSDA AND/OR THE REVIEWING AGENCY INFORMATION CONCERNING THE NUMBER OF PATIENTS TREATED, THE NUMBER AND TYPE OF PROCEDURES PERFORMED, AND OTHER DATA AS REQUIRED.

Yes. The applicant will provide the requested data consistent with Federal HIPAA requirements.

PROOF OF PUBLICATION

Attached.

DEVELOPMENT SCHEDULE

1. PLEASE COMPLETE THE PROJECT COMPLETION FORECAST CHART ON THE NEXT PAGE. IF THE PROJECT WILL BE COMPLETED IN MULTIPLE PHASES, PLEASE IDENTIFY THE ANTICIPATED COMPLETION DATE FOR EACH PHASE.

The Project Completion Forecast Chart is provided after this page.

2. IF THE RESPONSE TO THE PRECEDING QUESTION INDICATES THAT THE APPLICANT DOES NOT ANTICIPATE COMPLETING THE PROJECT WITHIN THE PERIOD OF VALIDITY AS DEFINED IN THE PRECEDING PARAGRAPH, PLEASE STATE BELOW ANY REQUEST FOR AN EXTENDED SCHEDULE AND DOCUMENT THE "GOOD CAUSE" FOR SUCH AN EXTENSION.

Not applicable. The applicant anticipates completing the project within the period of validity.

PROJECT COMPLETION FORECAST CHART

Enter the Agency projected Initial Decision Date, as published in Rule 68-11-1609(c):

10-22-14

Assuming the CON decision becomes the final Agency action on that date, indicate the number of days from the above agency decision date to each phase of the completion forecast.

PHASE	DAYS REQUIRED	Anticipated Date (MONTH /YEAR)
1. Architectural & engineering contract signed		10/2014
2. Construction documents approved by TDH		12/2014
3. Construction contract signed		11/2014
4. Building permit secured		11/2014
5. Site preparation completed		12/2014
6. Building construction commenced		1/2015
7. Construction 40% complete		5/2015
8. Construction 80% complete		9/2015
9. Construction 100% complete		12/2015
10. * Issuance of license		12/2015
11. *Initiation of service		1/2016
12. Final architectural certification of payment		3/2016
13. Final Project Report Form (HF0055)		5/2016

*** For projects that do NOT involve construction or renovation: please complete items 10-11 only.**

Note: If litigation occurs, the completion forecast will be adjusted at the time of the final determination to reflect the actual issue date.

PROJECT COMPLETION FORECAST CHART

Enter the Agency projected Initial Decision Date, as published in Rule 68-11-1609(c):

10-22-14

Assuming the CON decision becomes the final Agency action on that date, indicate the number of days from the above agency decision date to each phase of the completion forecast.

10-22-14

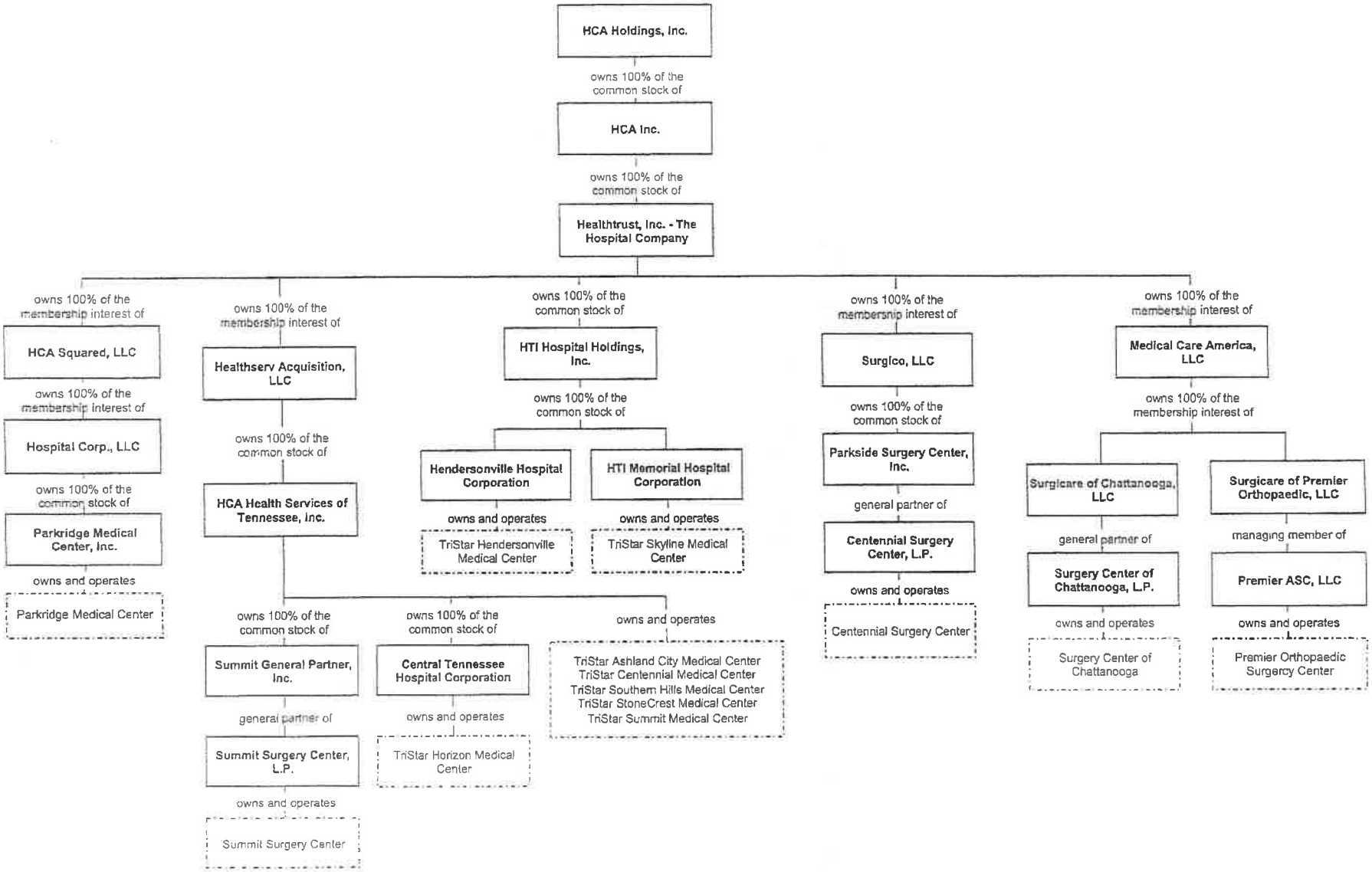
PHASE	DAYS REQUIRED	Anticipated Date (MONTH /YEAR)
1. Architectural & engineering contract signed	2	10/2014
2. Construction documents approved by TDH	36	12/2014
3. Construction contract signed	38	11/2014
4. Building permit secured	40	11/2014
5. Site preparation completed	65	12/2014
6. Building construction commenced	66	1/2015
7. Construction 40% complete	216	5/2015
8. Construction 80% complete	336	9/2015
9. Construction 100% complete	456	12/2015
10. * Issuance of license	484	12/2015
11. *Initiation of service	487	1/2016
12. Final architectural certification of payment	547	3/2016
13. Final Project Report Form (HF0055)	607	5/2016

*** For projects that do NOT involve construction or renovation: please complete items 10-11 only.**

Note: If litigation occurs, the completion forecast will be adjusted at the time of the final determination to reflect the actual issue date.

INDEX OF ATTACHMENTS

A.4	Ownership--Legal Entity and Organization Chart (if applicable)
A.6	Site Control
B.II.A.	Square Footage and Costs Per Square Footage Chart
B.III.	Plot Plan
B.IV.	Floor Plan
C, Need--1.A.3.	Letters of Intent & Qualifications
C, Need--3	Service Area Maps
C, Economic Feasibility--1	Documentation of Construction Cost Estimate
C, Economic Feasibility--2	Documentation of Availability of Funding
C, Economic Feasibility--10	Applicant's Financial Statements
C, Orderly Development--7(C)	Licensing & Accreditation Inspections
Miscellaneous Information	TennCare Enrollment Data U.S. Census QuickFacts County Data Sheets
Support Letters	

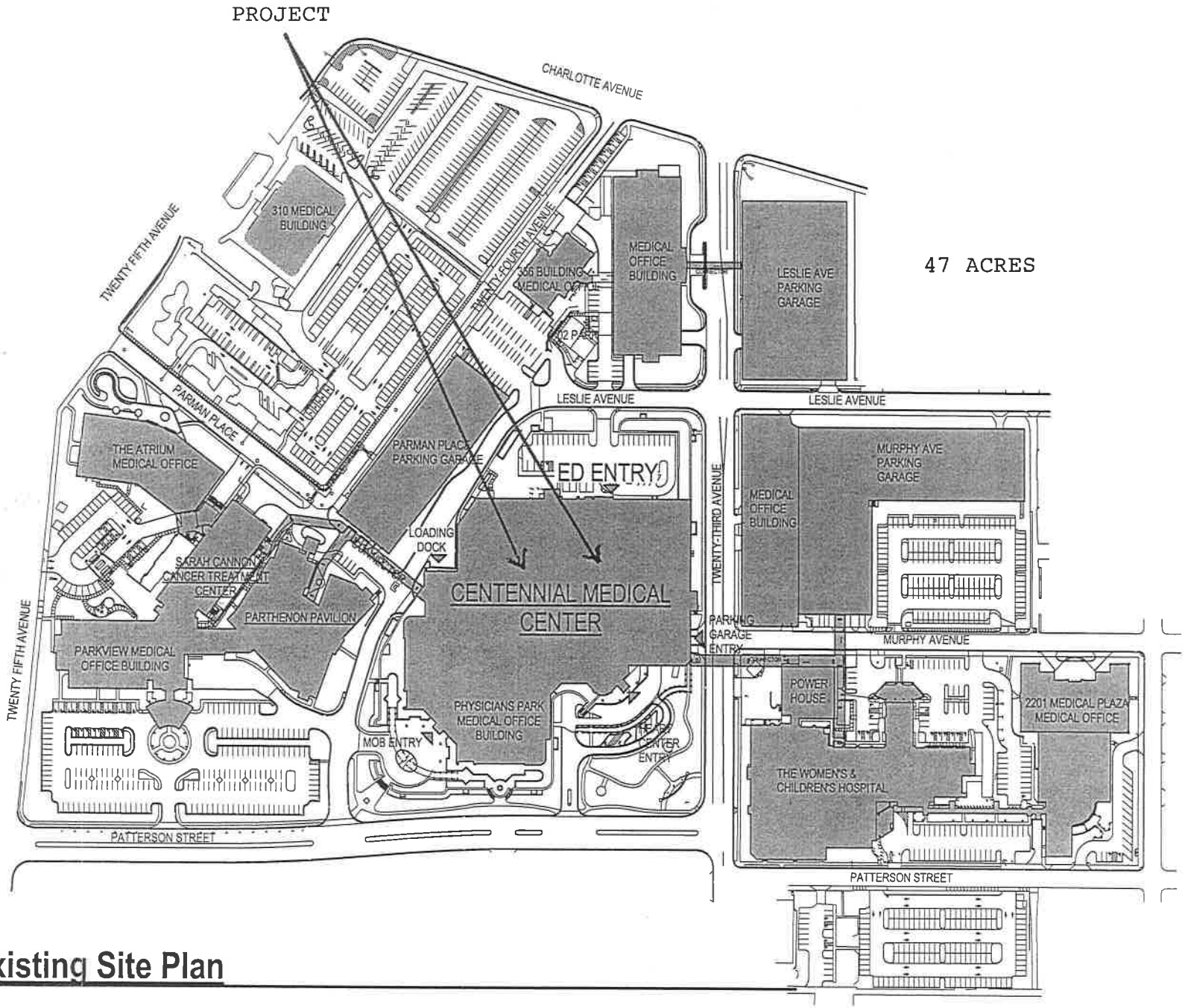

HCA Holdings, Inc.
owns 100% of the common stock of
HCA Inc.
owns 100% of the common stock of
Healthtrust, Inc. - The Hospital Company
owns 100% of the membership interest of
HCA Squared, LLC
owns 100% of the membership interest of
Hospital Corp., LLC
owns 100% of the common stock of
Parkridge Medical Center, Inc.
owns and operates
Parkridge Medical Center
owns 100% of the membership interest of
Healthserv Acquisition, LLC
owns 100% of the common stock of
HCA Health Services of Tennessee, Inc.
owns 100% of the common stock of
Summit General Partner, Inc.
general partner of
Summit Surgery Center, L.P.
owns and operates
Summit Surgery Center
owns 100% of the common stock of
Central Tennessee Hospital Corporation
owns and operates
TriStar Horizon Medical Center
owns and operates
TriStar Ashland City Medical Center
TriStar Centennial Medical Center
TriStar Southern Hills Medical Center
TriStar StoneCrest Medical Center
TriStar Summit Medical Center
owns 100% of the common stock of
HTI Hospital Holdings, Inc.
owns 100% of the common stock of
Hendersonville Hospital Corporation
owns and operates
TriStar Hendersonville Medical Center
HTI Memorial Hospital Corporation
owns and operates
TriStar Skyline Medical Center
owns 100% of the membership interest of
Surgico, LLC
owns 100% of the common stock of
Parkside Surgery Center, Inc.
general partner of
Centennial Surgery Center, L.P.
owns and operates
Centennial Surgery Center
owns 100% of the membership interest of
Medical Care America, LLC
owns 100% of the membership interest of
Surgicare of Chattanooga, LLC
general partner of
Surgery Center of Chattanooga, L.P.
owns and operates
Surgery Center of Chattanooga
Surgicare of Premier Orthopaedic, LLC
managing member of
Premier ASC, LLC
owns and operates
Premier Orthopaedic Surgery Center

B.II.A.--Square Footage and Costs Per Square Footage Chart

SQUARE FOOTAGE AND COST PER SQUARE FOOTAGE CHART

A. Unit / Department	Existing Location	Existing SF	Temporary Location	Proposed Final Location	Proposed Final Square Footage			Proposed Final Cost / SF		
					Renovated	New	Total	Renovated	New	Total
Emergency	1st Floor	12,250	NA	1st Floor	18,129		18,129	$242.00	$358.82	$4,387,218.00
Motor Lobby & Elevators	NA	NA	NA	Ground - 8th	19,944	3,828	23,772	$242.00	$358.82	$6,200,010.96
Med/Surg/Ortho (29)	NA	NA	NA	7th Floor	22,388		22,388	$242.00	$358.82	$5,417,896.00
Ortho Surgery & Prep/PACU	NA	NA	NA	8th Floor	23,932	25,271	49,203	$242.00	$358.82	$14,859,284.22
Med/Surg Beds (36)	8th Floor	26,572	NA	9th Floor		26,572	26,572	$242.00	$358.82	$9,534,565.04
Other Areas	NA	NA	NA	NA	825	3,050	3,875	$242.00	$358.82	$1,294,051.00
B. Unit/Dept. GSF Sub-Total					85,218	58,721	143,939			$41,693,025.22
C. Mechanical / Electrical GSF	NA	NA	NA	Powerhouse, 9th & 10th Floors	4,100	23,302	27,402	$242.00	$358.82	$9,353,423.64
D. Circulation / Structure GSF										
E. Total GSF					89,318	82,023	171,341			$51,046,448.86
Renovation										
Canopies	NA	NA	NA	ED 1st Floor		2,100	2,100	$242.00	$358.82	$753,522.00
GRAND TOTAL					89,318	84,123	173,441			$51,799,970.86

B.III.--Plot Plan



Existing Site Plan

TriStar Centennial
MEDICAL CENTER

CON PACKAGE

06/20/14

CENTENNIAL MEDICAL CENTER

2300 Patterson St.
Nashville, TN 37203

A0

EXISTING SITE PLAN

ESa

14048.01

B.IV.--Floor Plan

1 Physicians Park
2400 Patterson Street
- Physician Offices

2 Parthenon Pavilion
2401 Parman Place
See Receptionist upon entering

3 Sarah Cannon Building
2410 Patterson Street
1st Floor
- Outpatient Rehabilitation
- Sarah Cannon Cancer Center

230 25th Avenue North
2nd Floor
- Connector to Centennial Tower
- Patient Rooms
- Physician Offices

3rd - 4th Floors
- Patient Rooms
- Physician Offices

5th Floor
- Physician Offices

4 Atrium Building
250 25th Avenue North
- Atrium Plastic Surgery
- Center for Blood Cancers
- Physician Offices
- Sarah Cannon Research Institute

5 310 Building
310 25th Avenue North
- Physician Offices

6 356 Building
356 24th Avenue North
- Centennial Imaging Center
- Physician Offices

7 Centennial Professional Plaza/Surgery Center
345 23rd Avenue North
- Centennial Surgery Center
- Physician Offices

8 Centennial Tower
2300 Patterson Street
1st Floor
- Chapel/Chaplain Services
- Emergency Department
- Medical Imaging
- Patient Information
- Registration/Pre-Admission
- Security

2nd Floor
- Connector to Women's & Children's Hospital and other Centennial Buildings
- Food Court
- Gift Shop
- Patient Rooms
- Pediatric ICU

Centennial Tower (con't)
3rd Floor
- Centennial Heart & Vascular Center

4th – 8th Floors
- Patient Rooms

9 Tace Building
2200 Murphy Avenue
- Centennial Center for the Treatment of Obesity
- Physician Offices

10 Women's & Children's Hospital
2221 Murphy Avenue
1st Floor
- Gift Shop
- OB/GYN ER
- Patient Information
- Patient Registration

2nd Floor
- Café
- Connector to 2201 Medical Plaza
- Kids Express
- Medical Records

Women's & Children's (con't)
3rd Floor
- Connector to Tower
- Patient Rooms

4th - 8th Floors
- Patient Rooms

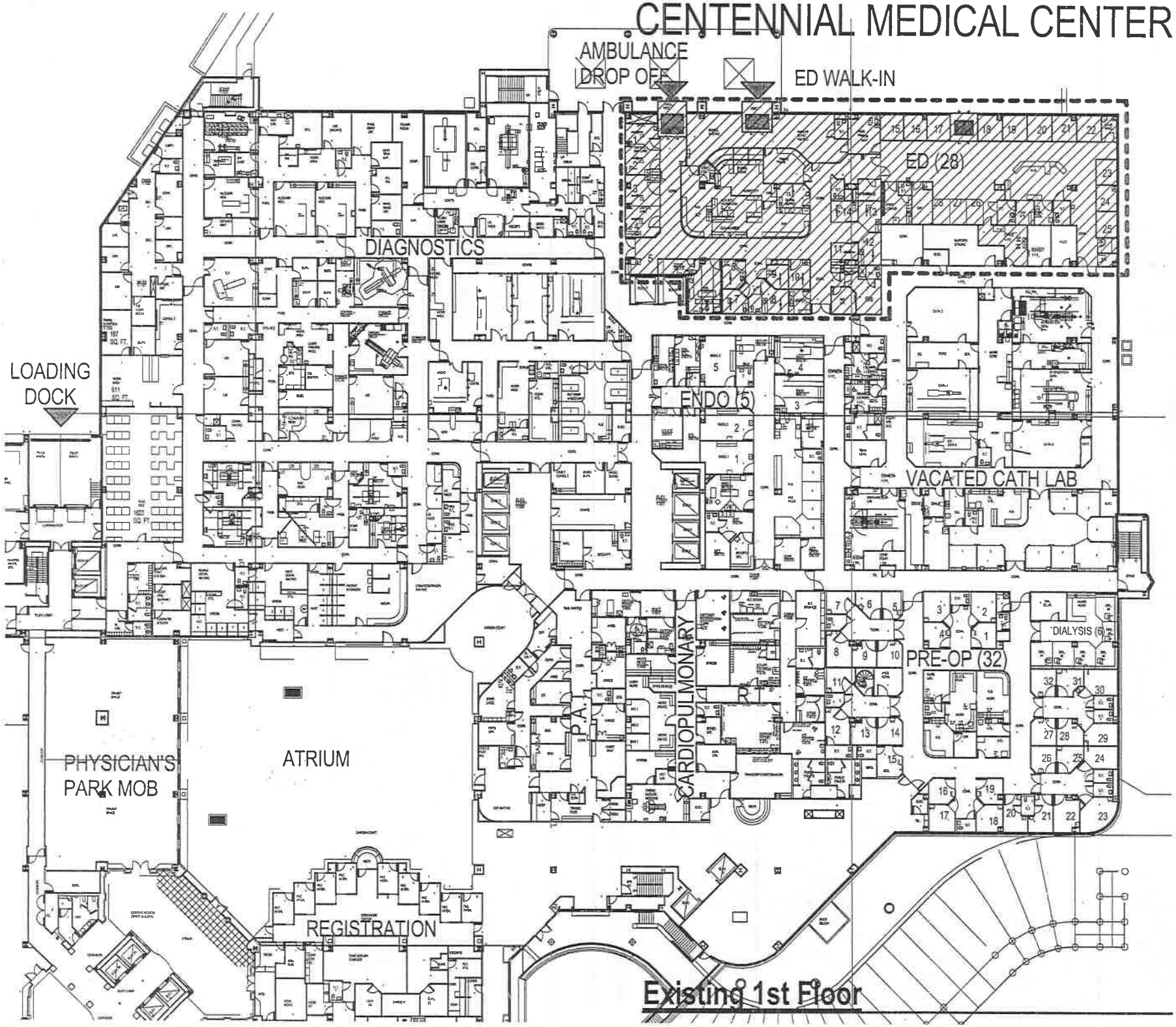
11 2201 Medical Plaza Building
2201 Murphy Avenue
- Auditorium
- Physician Offices

12 Building C
310 23rd Avenue North
- Physician Offices

13 2222 State Street
- Physician Offices
- Sleep Disorders Center

14 Medical Park
330 23rd Avenue North
- Centennial Endoscopy Center
- Physician Offices
- Women's Health & Imaging Center

CENTENNIAL MEDICAL CENTER



TriStar Centennial MEDICAL CENTER

CON PACKAGE

06/20/14

CENTENNIAL MEDICAL CENTER

2300 Patterson St.
Nashville, TN 37203

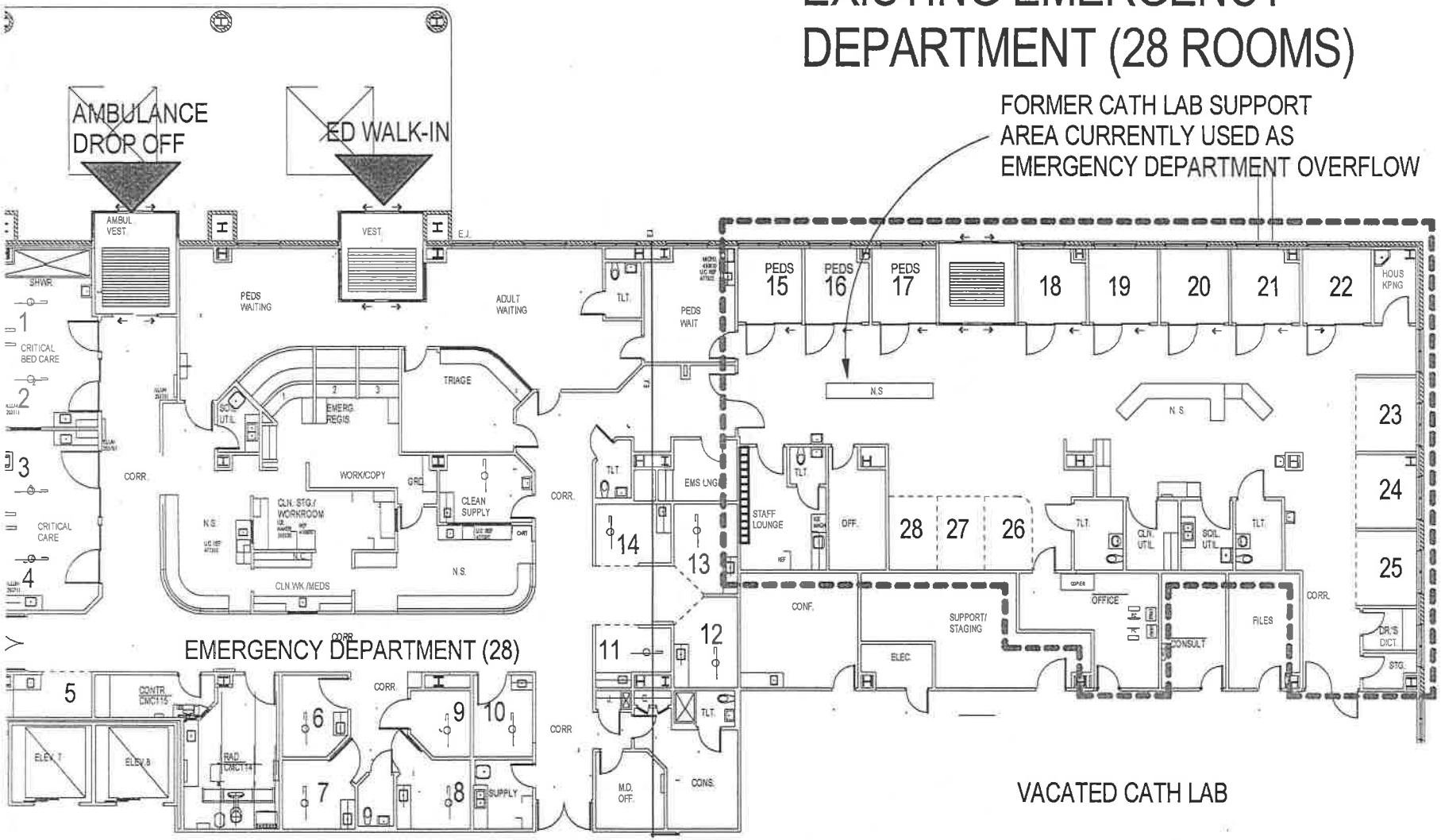
A1

EXISTING FIRST FLOOR OF CMC TOWER

ESa

14048.01

EXISTING EMERGENCY DEPARTMENT (28 ROOMS)



Existing 1st Floor - ED Enlarged

TriStar Centennial MEDICAL CENTER

CON PACKAGE

06/20/14

CENTENNIAL MEDICAL CENTER

2300 Patterson St.
Nashville, TN 37203

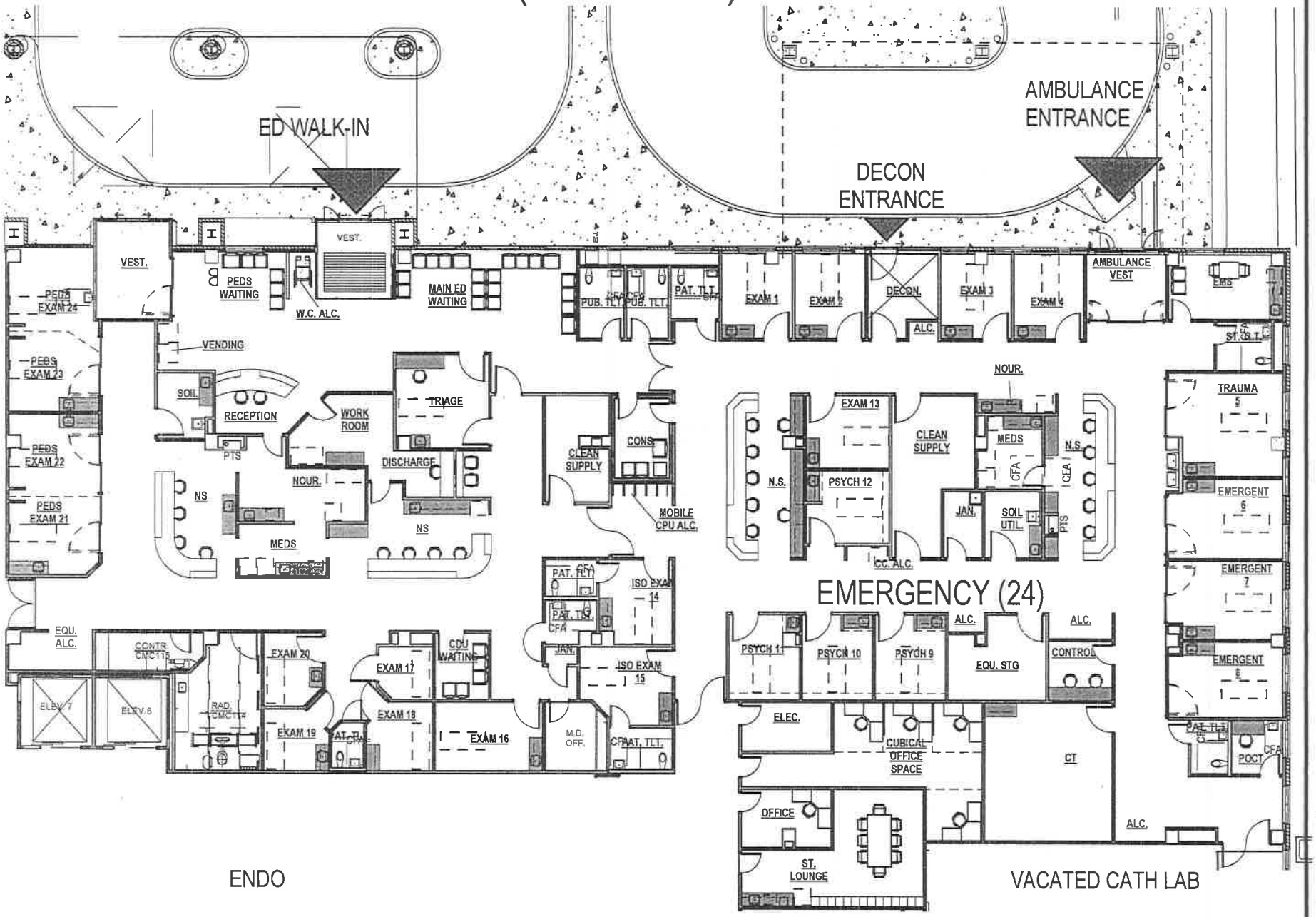
A2

EXISTING ED

ESa

14048.01

PROPOSED EMERGENCY DEPARTMENT (24 ROOMS)



1st Floor ED

TriStar Centennial MEDICAL CENTER

CON PACKAGE

06/20/14

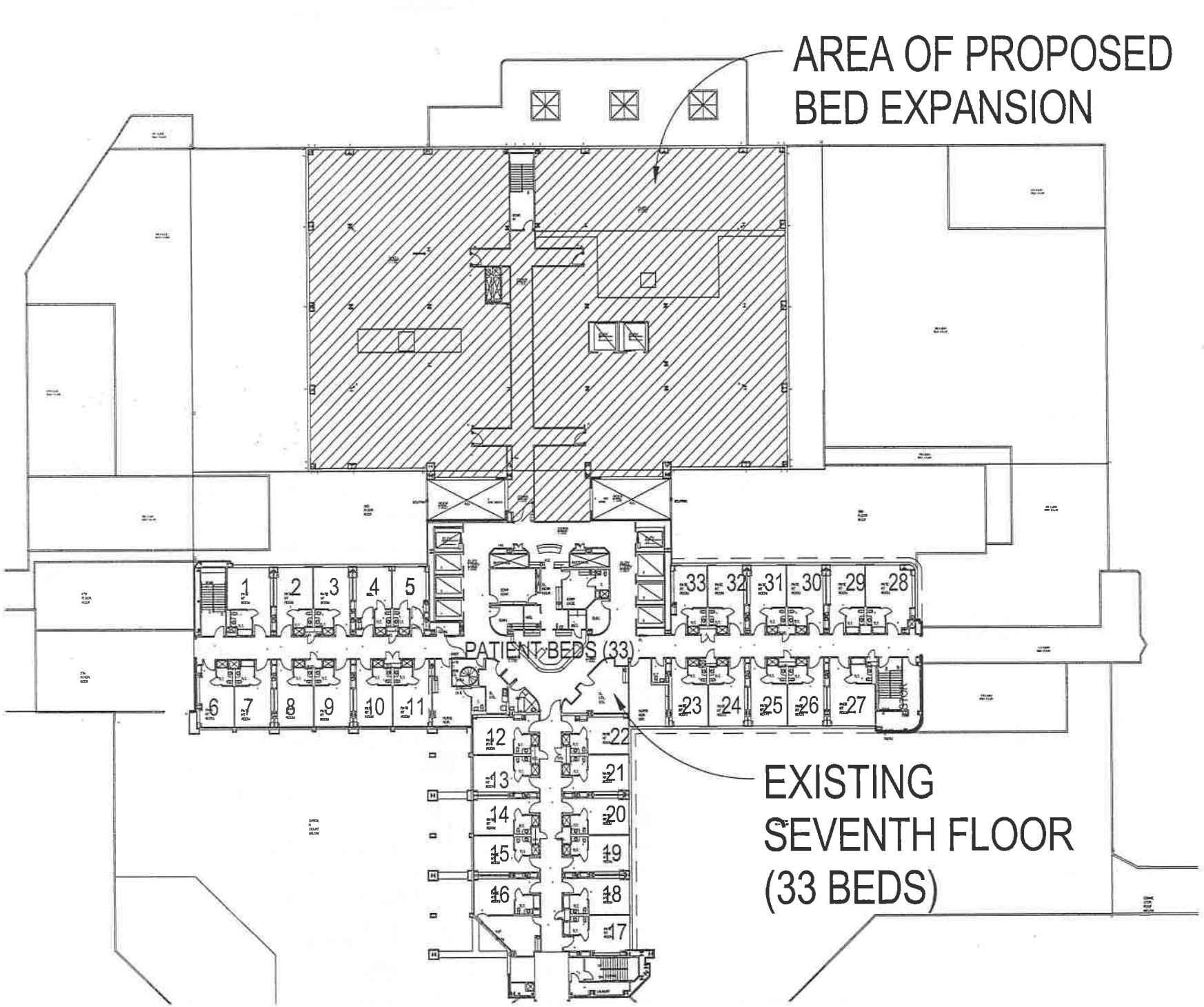
CENTENNIAL MEDICAL CENTER

2300 Patterson St.
Nashville, TN 37203

A3
PROPOSED EMERGENCY DEPARTMENT

ESa

14048.01



Existing 7th Floor

TriStar Centennial
MEDICAL CENTER

CON PACKAGE

06/20/14

CENTENNIAL
MEDICAL CENTER

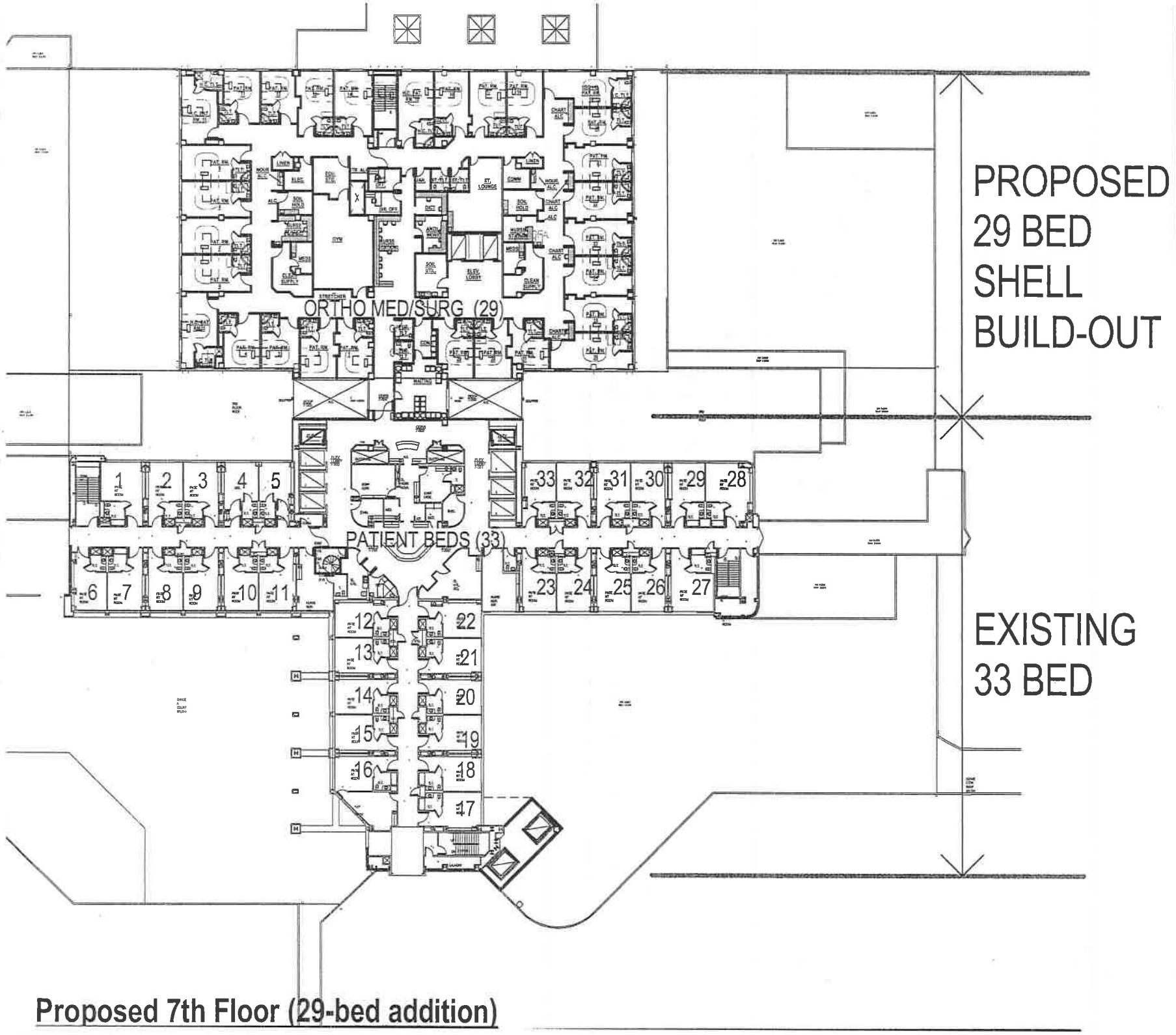
2300 Patterson St.
Nashville, TN 37203

A4

EXISTING 7TH FLOOR -
33 BEDS

ESa

14048.01



Proposed 7th Floor (29-bed addition)

TriStar Centennial
MEDICAL CENTER

CON PACKAGE

06/20/14

CENTENNIAL
MEDICAL CENTER

2300 Patterson St.
Nashville, TN 37203

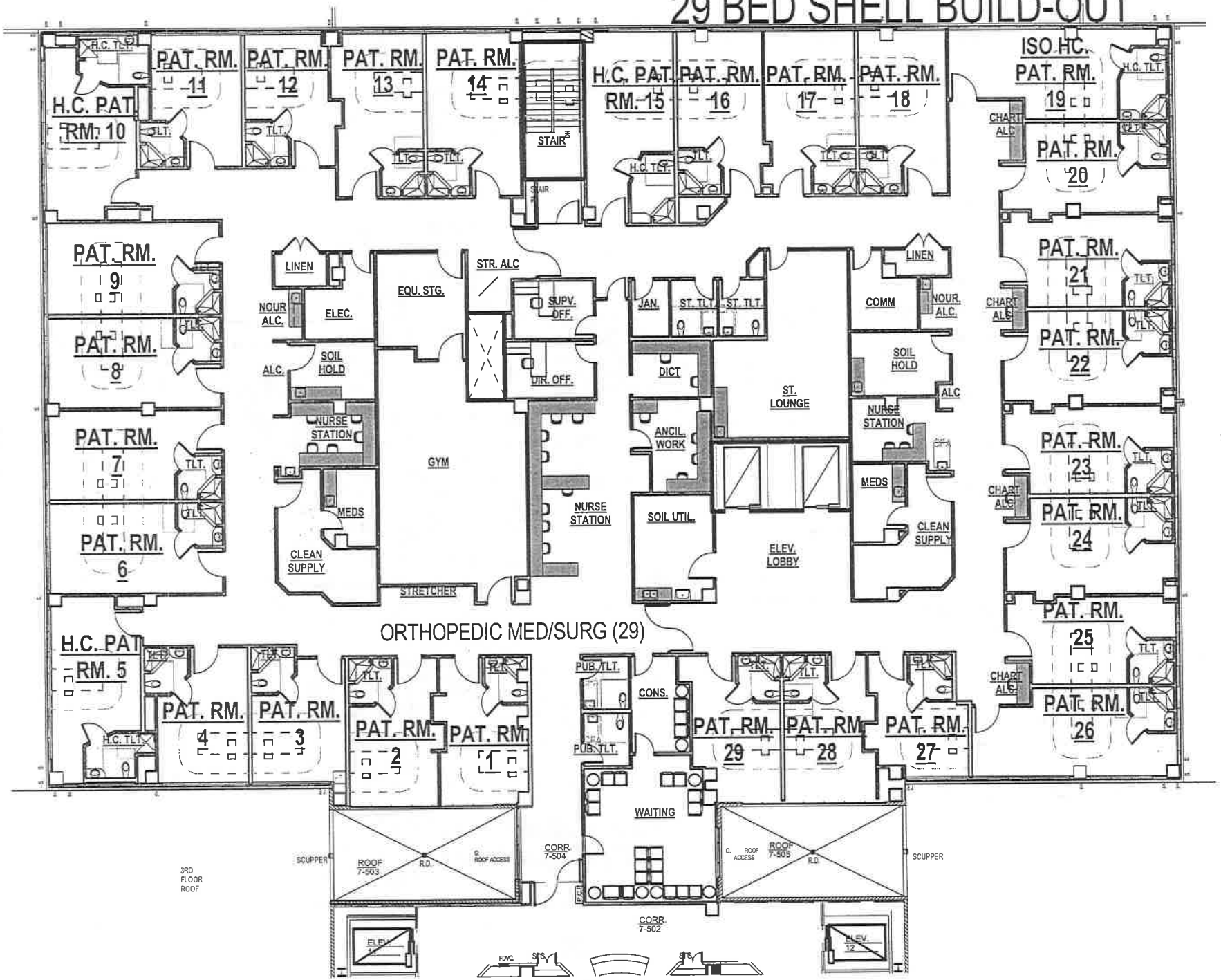
A5

PROPOSED SEVENTH
FLOOR - 29 BEDS

ESa

14048.01

SEVENTH FLOOR -PROPOSED
29 BED SHELL BUILD-OUT



Proposed 7th Floor (29 Bed Shell Build-Out)

TriStar Centennial MEDICAL CENTER

CON PACKAGE

06/20/14

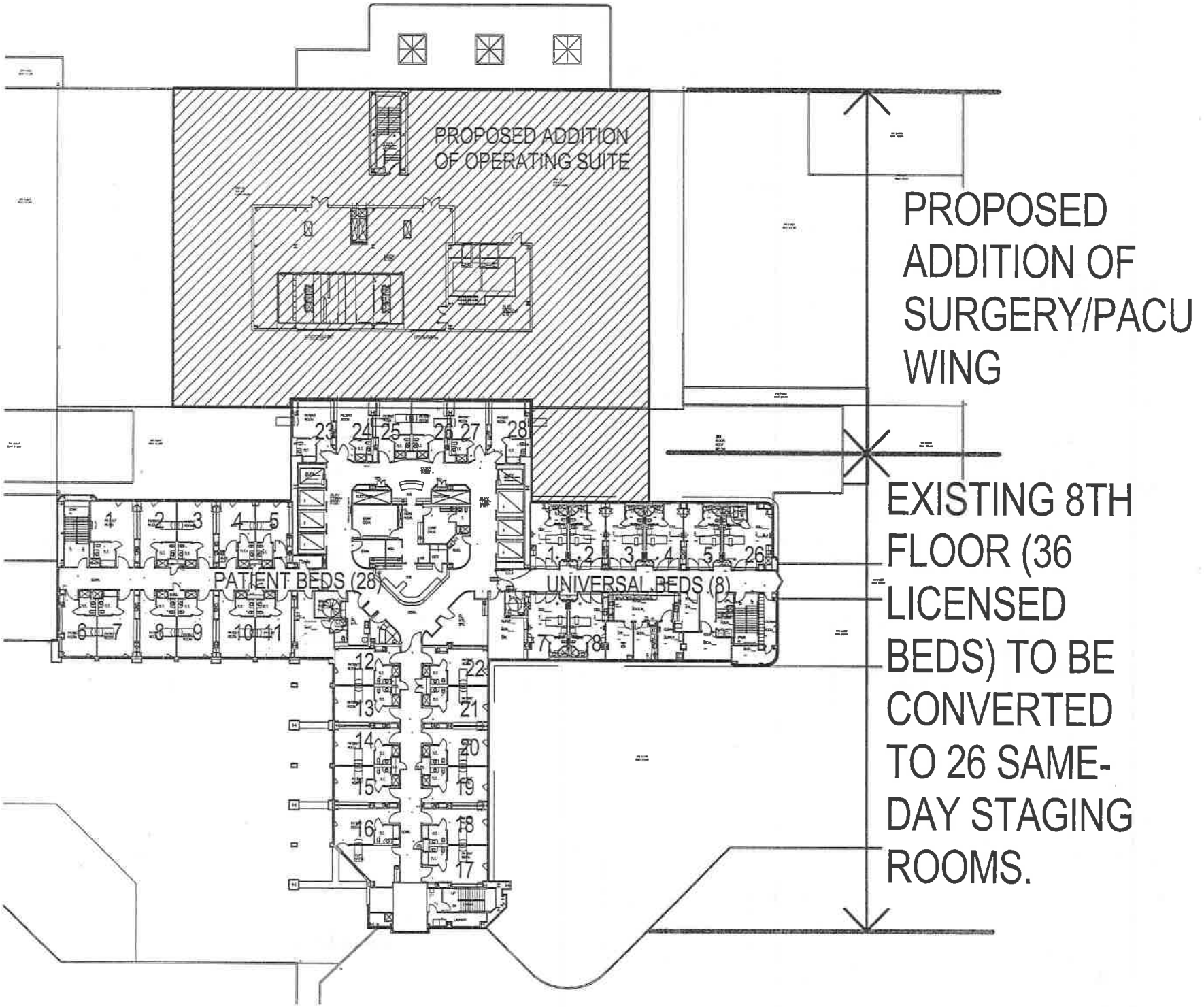
CENTENNIAL MEDICAL CENTER

2300 Patterson St.
Nashville, TN 37203

A6
SEVENTH FLOOR - PROPOSED 29 BED ADDITION

ESa

14048.01



Existing 8th Floor

TriStar Centennial MEDICAL CENTER

CON PACKAGE

06/20/14

CENTENNIAL MEDICAL CENTER

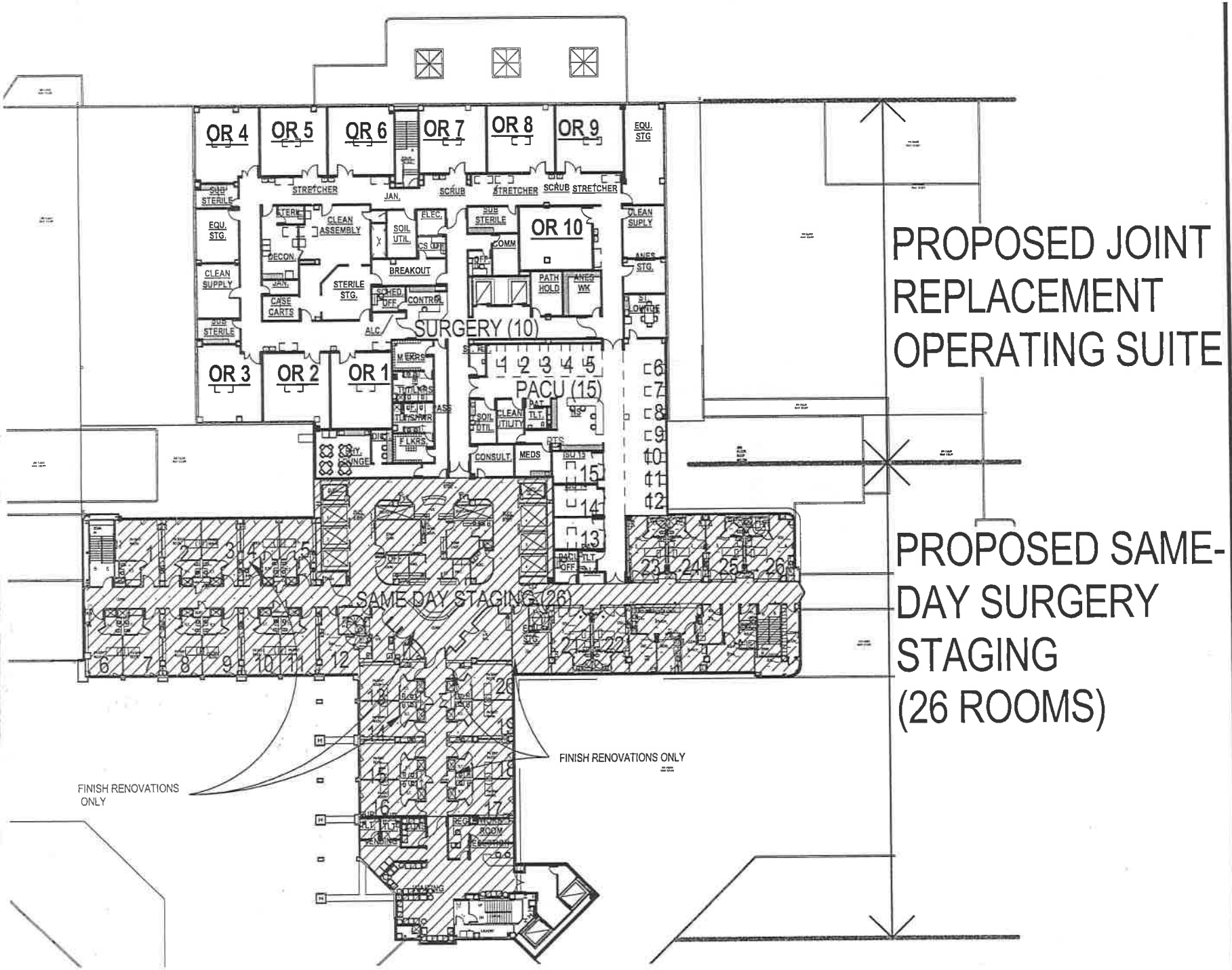
2300 Patterson St.
Nashville, TN 37203

A7

EXISTING EIGHTH FLOOR

ESa

14048.01



PROPOSED JOINT REPLACEMENT OPERATING SUITE

PROPOSED SAME-DAY SURGERY STAGING (26 ROOMS)

Proposed 8th Floor

TriStar Centennial MEDICAL CENTER

CON PACKAGE

06/20/14

CENTENNIAL MEDICAL CENTER

2300 Patterson St.
Nashville, TN 37203

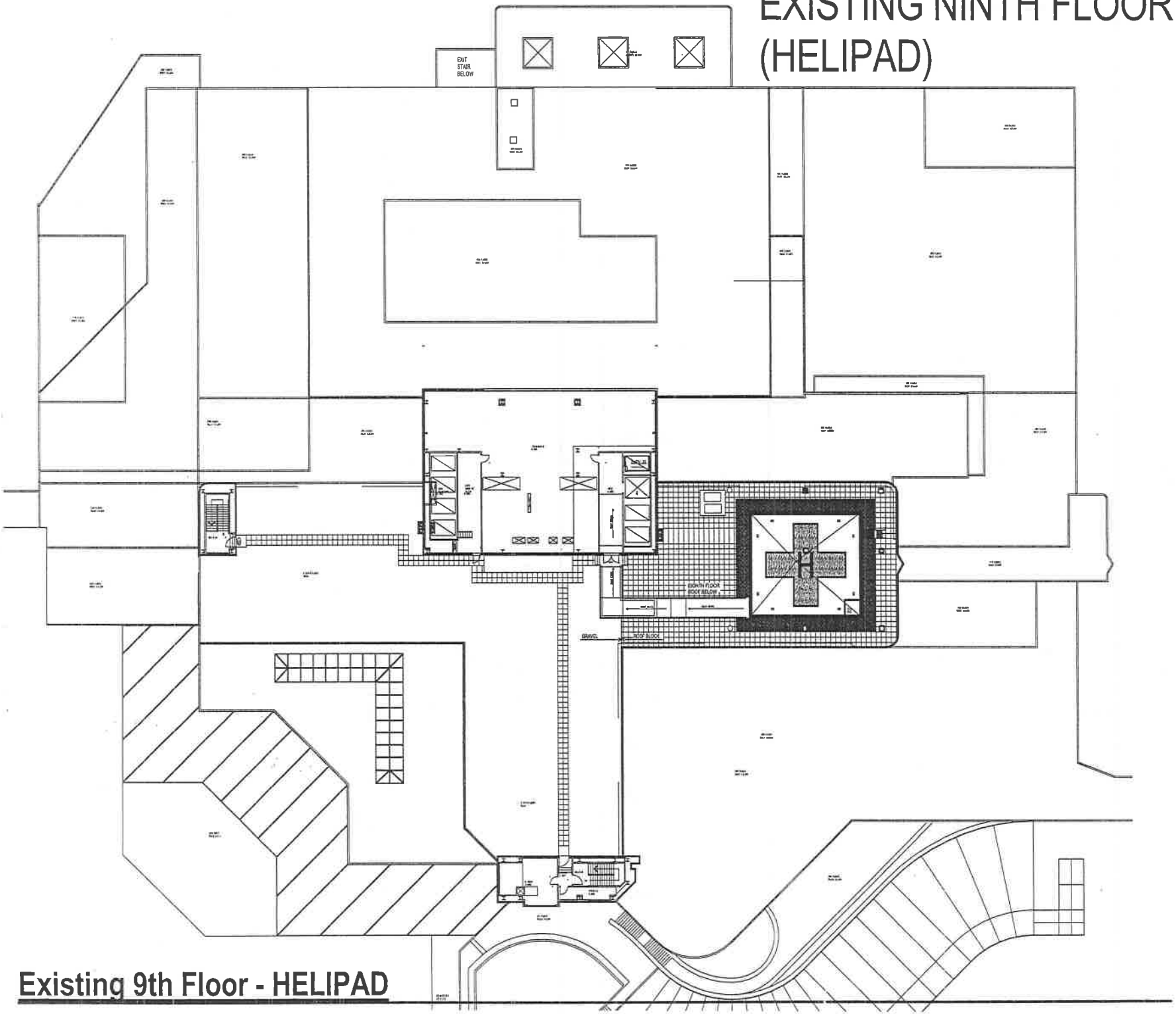
A8

PROPOSED 8TH FLOOR - SURGERY

ESa

14048.01

EXISTING NINTH FLOOR (HELIPAD)



Existing 9th Floor - HELIPAD

TriStar Centennial MEDICAL CENTER

CON PACKAGE

06/20/14

CENTENNIAL MEDICAL CENTER

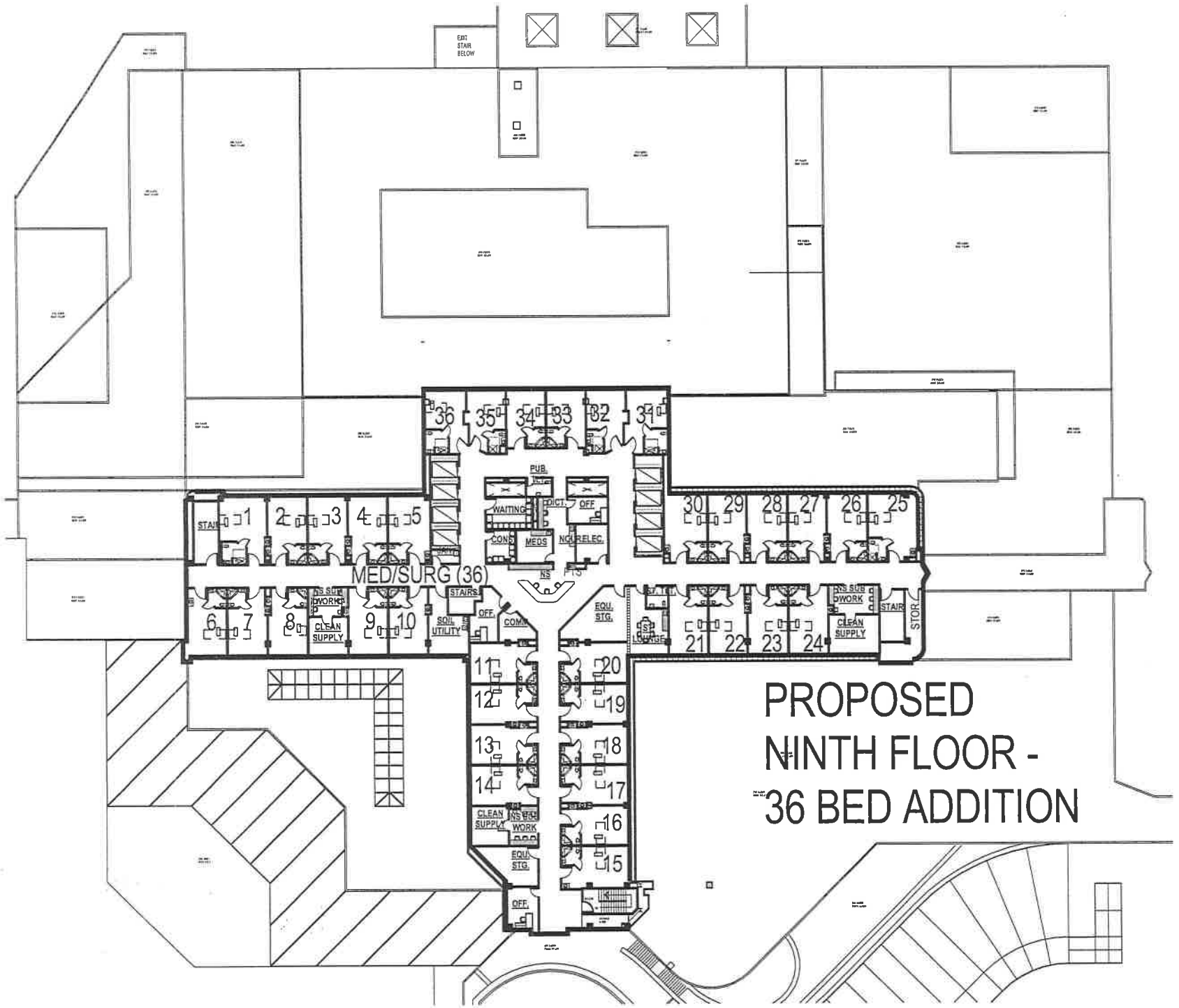
2300 Patterson St.
Nashville, TN 37203

A9

EXISTING NINTH FLOOR HELIPAD

ESa

14048.01



Proposed Ninth Floor - 36 Bed Addition

TriStar Centennial MEDICAL CENTER

CON PACKAGE

06/20/14

CENTENNIAL MEDICAL CENTER

2300 Patterson St.
Nashville, TN 37203

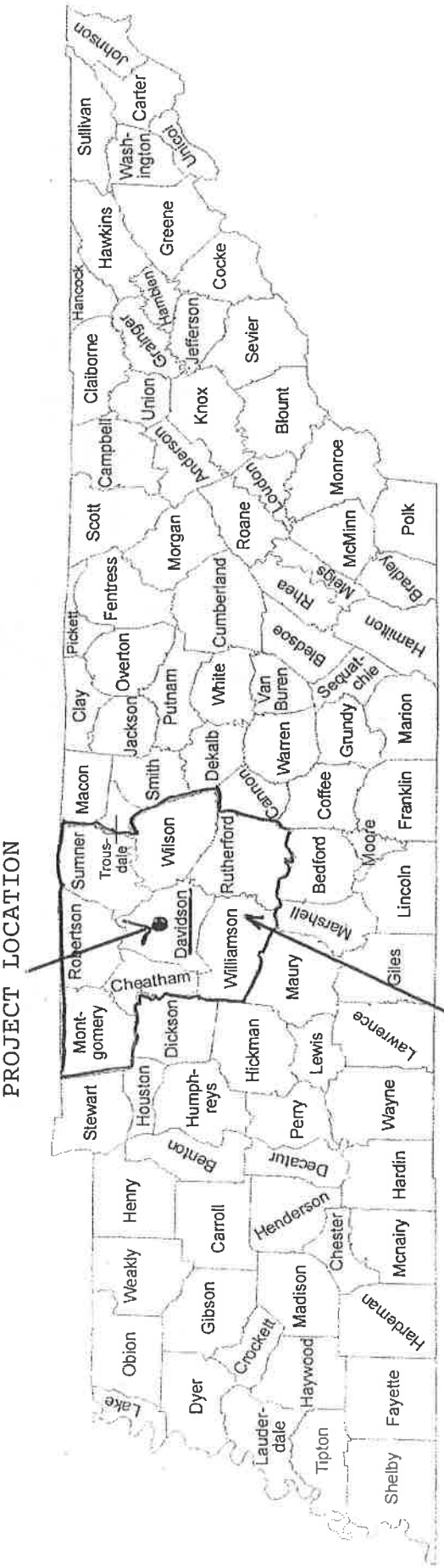
A10

PROPOSED 9TH FLOOR - 36 BED ADDITION

ESa

14048.01

C, Need--3
Service Area Maps

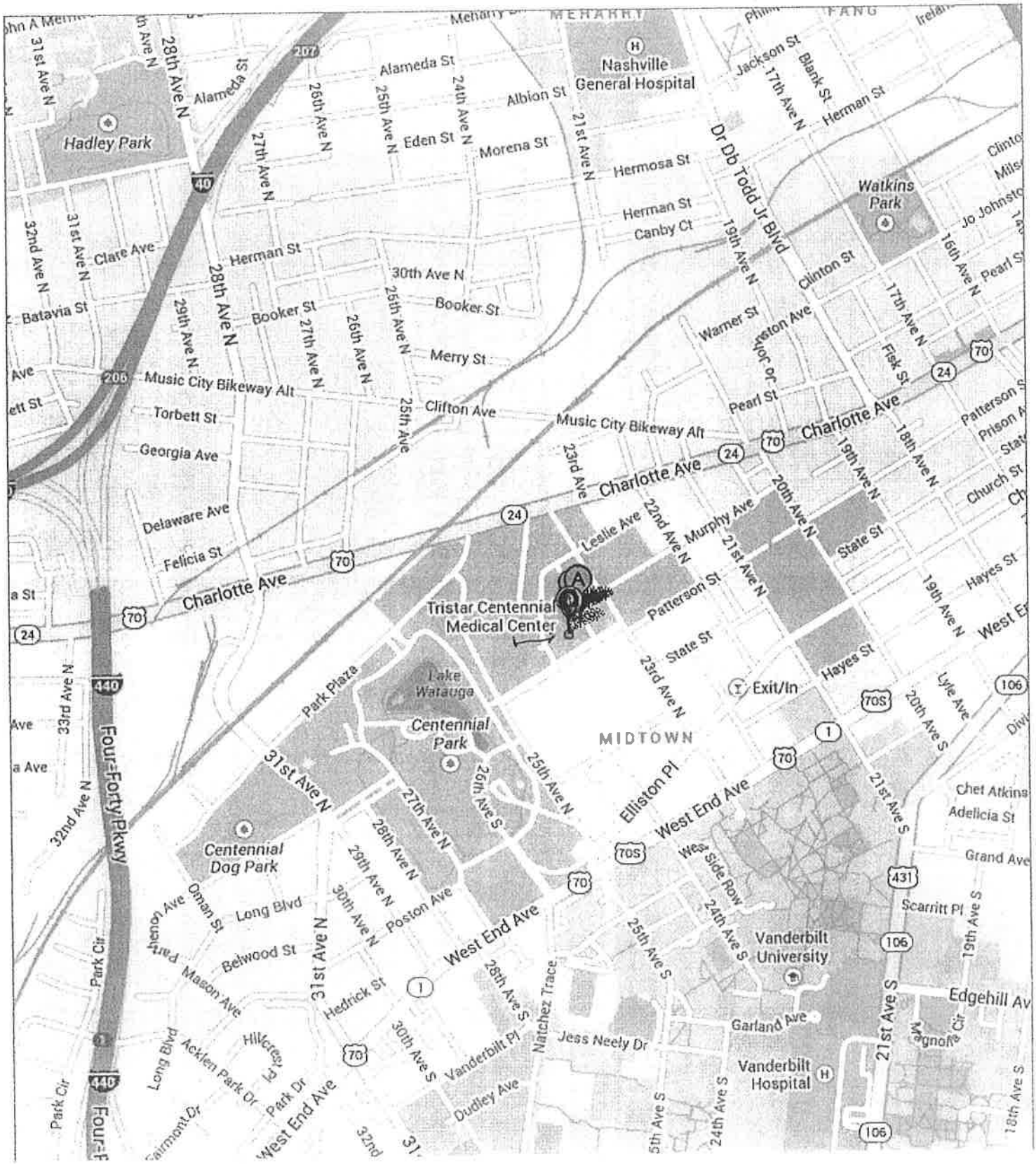

PROJECT LOCATION
EIGHT-COUNTY
PRIMARY SERVICE AREA
Johnson
Carter
Unicoi
Sullivan
Wash-ington
Greene
Hawkins
Hancock
Hamblen
Cocke
Grainger
Jefferson
Sevier
Claiborne
Union
Knox
Blount
Campbell
Anderson
Loudon
Monroe
Scott
Morgan
Roane
McMinn
Polk
Bradley
Fentress
Meigs
Rhea
Hamilton
Pickett
Overton
Cumberland
Bledsoe
Sequat-chie
Clay
Jackson
Putnam
White
Van Buren
Grundy
Marion
Macon
Smith
Dekalb
Warren
Coffee
Franklin
Sumner
Trous-dale
Wilson
Cannon
Rutherford
Moore
Bedford
Lincoln
Robertson
Davidson
Williamson
Marshall
Giles
Cheatham
Maury
Lawrence
Mont-gomery
Dickson
Hickman
Lewis
Stewart
Houston
Humph-reys
Perry
Wayne
Benton
Decatur
Henry
Carroll
Henderson
Hardin
Weakly
Chester
Mcnairy
Obion
Gibson
Madison
Hardeman
Crockett
Dyer
Haywood
Fayette
Lake
Lauder-dale
Tipton
Shelby

To see all the details that are visible on the screen, use the "Print" link next to the map.

Google

To see all the details that are visible on the screen, use the "Print" link next to the map.

Google



C, Economic Feasibility--1
Documentation of Construction Cost Estimate

ESa Earl Swensson Associates, Inc.
richard l. miller, architect
Architecture

July 14, 2014

Ms. Melanie Hill
Executive Director
Tennessee Health Services and Development Agency
161 Rosa Parks Boulevard
Nashville, TN 37203

RE: CENTENNIAL MEDICAL CENTER:
ORTHOPEDIC AND EMERGENCY EXPANSION & RENOVATION PROJECTS
NASHVILLE, TENNESSEE

Dear Ms. Hill,

Earl Swensson Associates, Inc. has reviewed the construction cost estimate provided by HCA Construction Management. Based on our experience and knowledge of the current healthcare market, it is our opinion that the projected cost of $51,800,000 at ±$300 per S.F. (averaged between new construction and renovation) appears to be reasonable for this project type and size.

Below is a summary of the current building codes enforced for this project. This listing may not be entirely inclusive, but the intent is for all applicable codes and standards, State and Local, to be addressed during the design process. The codes in effect at the time of submittal of plans and specifications shall be the codes to be used throughout the project.

- International Building Code
- International Energy Conservation Code
- International Mechanical Code
- International Plumbing Code
- International Fuel Gas Code
- International Fire Code (with local amendments)
- NFPA 101 Life Safety Code
- National Electrical Code
- Guidelines for the Design and Construction of Health Care Facilities
- Rules of TN Department of Health Board for Licensing Health Care Facilities

Sincerely,

EARL SWENSSON ASSOCIATES, INC.

Randel Forkum, AIA

C, Economic Feasibility--2
Documentation of Availability of Funding

TriStar Health

TriStarHealth.com

110 Winners Circle, First Floor
Brentwood, TN 37027
(615) 886-4900

July 10, 2014

Melanie Hill, Executive Director
Tennessee Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243

RE: TriStar Centennial Medical Center
Joint Replacement Center and Emergency Department Renovation

Dear Mrs. Hill:

TriStar Centennial Medical Center is applying for a Certificate of Need to update its main Tower Emergency Department and to establish a Center of Excellence for Joint Replacement Surgery, with dedicated inpatient beds and operating rooms.

As President and CFO of TriStar Health System, the HCA Division Office to which this facility belongs, we are writing to confirm that HCA Holdings, Inc., the parent company for HCA and for this facility, will provide through TriStar the estimated $96,193,000 in capital funding required to implement this project. HCA Holdings Inc.'s financial statements are provided in the application.

Sincerely,

Stephen E. Corbeil, FACHE
President
TriStar Health System, a Division of HCA

C. Eric Lawson
CFO
TriStar Health System, a Division of HCA

C, Economic Feasibility--10
Financial Statements

	8,036	**91.0**	7,879	93.4
Income before income taxes	**800**	**9.0**	555	6.6
Provision for income taxes	**246**	**2.7**	128	1.5
Net income	**554**	**6.3**	427	5.1
Net income attributable to noncontrolling interests	**130**	**1.5**	113	1.4
Net income attributable to HCA Holdings, Inc.	**$424**	**4.8**	$314	3.7
Diluted earnings per share	**$0.92**		$0.68	
Shares used in computing diluted earnings per share (000)	**458,535**		461,131	
Comprehensive income attributable to HCA Holdings, Inc.	**$541**		$297	

HCA Holdings, Inc.
Condensed Consolidated Comprehensive Income Statements
For the Years Ended December 31, 2013 and 2012
(Dollars in millions, except per share amounts)

	2013		2012	
	Amount	**Ratio**	Amount	Ratio
Revenues before provision for doubtful accounts	**$38,040**		$36,783	
Provision for doubtful accounts	**3,858**		3,770	
Revenues	**34,182**	**100.0%**	33,013	100.0%
Salaries and benefits	**15,646**	**45.8**	15,089	45.7
Supplies	**5,970**	**17.5**	5,717	17.3
Other operating expenses	**6,237**	**18.2**	6,048	18.3
Electronic health record incentive income	**(216)**	**(0.6)**	(336)	(1.0)
Equity in earnings of affiliates	**(29)**	**(0.1)**	(36)	(0.1)
Depreciation and amortization	**1,753**	**5.1**	1,679	5.1
Interest expense	**1,848**	**5.4**	1,798	5.4
Losses (gains) on sales of facilities	**10**	**-**	(15)	-
Loss on retirement of debt	**17**	**0.1**	-	-
Legal claim costs	**-**	**-**	175	0.5
	31,236	**91.4**	30,119	91.2
Income before income taxes	**2,946**	**8.6**	2,894	8.8
Provision for income taxes	**950**	**2.8**	888	2.7
Net income	**1,996**	**5.8**	2,006	6.1
Net income attributable to noncontrolling interests	**440**	**1.2**	401	1.2
Net income attributable to HCA Holdings, Inc.	**$1,556**	**4.6**	$1,605	4.9
Diluted earnings per share	**$3.37**		$3.49	
Shares used in computing diluted earnings per share (000)	**461,913**		459,403	
Comprehensive income attributable to HCA Holdings, Inc.	**$1,756**		$1,588	

HCA Holdings, Inc.
Supplemental Non-GAAP Disclosures
Operating Results Summary
(Dollars in millions, except per share amounts)

For the Years

	Fourth Quarter		Ended December 31,	
	2013	2012	2013	2012
Revenues	**$8,836**	$8,434	**$34,182**	$33,013
Net income attributable to HCA Holdings, Inc.	**$424**	$314	**$1,556**	$1,605
Losses (gains) on sales of facilities (net of tax)	**(2)**	(6)	**7**	(9)
Loss on retirement of debt (net of tax)	**-**	-	**11**	-
Legal claim costs (net of tax)	**-**	110	**-**	110
Net income attributable to HCA Holdings, Inc., excluding losses (gains) on sales of facilities, loss on retirement of debt and legal claim costs (a)	**422**	418	**1,574**	1,706
Depreciation and amortization	**461**	425	**1,753**	1,679
Interest expense	**456**	462	**1,848**	1,798
Provision for income taxes	**245**	188	**959**	947
Net income attributable to noncontrolling interests	**130**	113	**440**	401
Adjusted EBITDA (a)	**$1,714**	$1,606	**$6,574**	$6,531
Diluted earnings per share:				
Net income attributable to HCA Holdings, Inc.	**$0.92**	$0.68	**$3.37**	$3.49
Losses (gains) on sales of facilities	**-**	(0.01)	**0.02**	(0.02)
Loss on retirement of debt	**-**	-	**0.02**	-
Legal claim costs	**-**	0.24	**-**	0.24
Net income attributable to HCA Holdings, Inc., excluding losses (gains) on sales of facilities, loss on retirement of debt and legal claim costs (a)	**$0.92**	$0.91	**$3.41**	$3.71
Shares used in computing diluted earnings per share (000)	**458,535**	461,131	**461,913**	459,403

(a) Net income attributable to HCA Holdings, Inc., excluding losses (gains) on sales of facilities, loss on retirement of debt and legal claim costs, and Adjusted EBITDA should not be considered as measures of financial performance under generally accepted accounting principles ("GAAP"). We believe net income attributable to HCA Holdings, Inc., excluding losses (gains) on sales of facilities, loss on retirement of debt and legal claim costs, and Adjusted EBITDA are important measures that supplement discussions and analysis of our results of operations. We believe it is useful to investors to provide disclosures of our results of operations on the same basis used by management. Management relies upon net income attributable to HCA Holdings, Inc., excluding losses (gains) on sales of facilities, loss on retirement of debt and legal claim costs, and Adjusted EBITDA as the primary measures to review and assess operating performance of its hospital facilities and their management teams.

Management and investors review both the overall performance (including:net income attributable to HCA Holdings)(including:Inc.)(including:excluding losses (gains) on sales of facilities, loss on retirement of debt and legal claim costs, and GAAP net income attributable to HCA Holdings, Inc.) and operating performance (Adjusted EBITDA) of our health care facilities. Adjusted EBITDA and the Adjusted EBITDA margin (Adjusted EBITDA divided by revenues) are utilized by management and investors to compare our current operating results with the corresponding periods during the previous year and to compare our operating results with other companies in the health care industry. It is reasonable to expect that losses (gains) on sales of facilities and losses on retirement of debt will occur in future periods, but the amounts recognized can vary significantly from period to period, do not directly relate to the ongoing operations of our health care facilities and complicate period comparisons of our results of operations and operations comparisons with other health care companies.

Net income attributable to HCA Holdings, Inc., excluding losses (gains) on sales of facilities, loss on retirement of debt and legal claim costs, and Adjusted EBITDA are not measures of financial performance under GAAP and should not be considered as alternatives to net income attributable to HCA Holdings, Inc. as a measure of operating performance or cash flows from operating, investing and financing activities as a measure of liquidity. Because net income attributable to HCA Holdings, Inc., excluding losses (gains) on sales of facilities, loss on retirement of debt and legal claim costs, and Adjusted EBITDA are not measurements determined in accordance with GAAP and are susceptible to varying calculations, net income attributable to HCA Holdings, Inc., excluding losses (gains) on sales of facilities, loss on retirement of debt and legal claim costs, and Adjusted EBITDA, as presented, may not be comparable to other similarly titled measures presented by other companies.

HCA Holdings, Inc.
Condensed Consolidated Balance Sheets

(Dollars in millions)

	December 31, 2013	September 30, 2013	December 31, 2012
ASSETS			
Current assets:			
Cash and cash equivalents	**$414**	$484	$705
Accounts receivable, net	**5,208**	4,924	4,672
Inventories	**1,179**	1,135	1,086
Deferred income taxes	**489**	400	385
Other	**747**	828	915
Total current assets	**8,037**	7,771	7,763
Property and equipment, at cost	**31,073**	30,472	29,527
Accumulated depreciation	**(17,454)**	(17,150)	(16,342)
	13,619	13,322	13,185
Investments of insurance subsidiaries	**448**	402	515
Investments in and advances to affiliates	**121**	125	104
Goodwill and other intangible assets	**5,903**	5,832	5,539
Deferred loan costs	**237**	250	290
Other	**466**	691	679
	$28,831	$28,393	$28,075
LIABILITIES AND STOCKHOLDERS' DEFICIT			
Current liabilities:			
Accounts payable	**$1,803**	$1,582	$1,768
Accrued salaries	**1,193**	1,085	1,120
Other accrued expenses	**1,913**	1,764	1,649
Long-term debt due within one year	**786**	988	1,435
Total current liabilities	**5,695**	5,419	6,172
Long-term debt	**27,590**	27,389	27,495
Professional liability risks	**949**	959	973
Income taxes and other liabilities	**1,525**	1,670	1,776
EQUITY (DEFICIT)			
Stockholders' deficit attributable to HCA Holdings, Inc.	**(8,270)**	(8,376)	(9,660)
Noncontrolling interests	**1,342**	1,332	1,319
Total deficit	**(6,928)**	(7,044)	(8,341)
	$28,831	$28,393	$28,075

HCA Holdings, Inc.
Condensed Consolidated Statements of Cash Flows
For the Years Ended December 31, 2013 and 2012
(Dollars in millions)

	2013	2012
Cash flows from operating activities:		
Net income	**$1,996**	$2,006
Adjustments to reconcile net income to net cash provided by operating activities:		
Changes in operating assets and liabilities	**(4,272)**	(3,663)
Provision for doubtful accounts	**3,858**	3,770
Depreciation and amortization	**1,753**	1,679
Income taxes	**143**	96
Losses (gains) on sales of facilities	**10**	(15)
Loss on retirement of debt	**17**	-
Legal claim costs	**-**	175
Amortization of deferred loan costs	**55**	62

Z00001 - Centennial Medical Center
Dec - 2013
All Entities

Financial Statements - Balance Sheet

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Report ID: ALCFS010

Month				Year to Date		
Begin	Change	Ending		Begin	Change	Ending
			CURRENT ASSETS			
97,147	-29,733	67,414	Cash & Cash Equivalents	82,991	-15,577	67,414
			Marketable Securities	323	-323	
			PATIENT ACCOUNTS RECEIVABLES			
125,527,830	9,438,561	134,966,391	Patient Receivables	120,546,644	14,419,747	134,966,391
			Less Allow for Govt Receivables			
-39,673,234	-5,690,432	-45,363,666	Less Allow - Bad Debt	-48,260,338	2,896,672	-45,363,666
85,854,596	3,748,129	89,602,725	Net Patient Receivables	72,286,306	17,316,419	89,602,725
			FINAL SETTLEMENTS			
-748,780	0	-748,780	Due to/from Govt Programs	-332,421	-416,359	-748,780
			Allowances Due Govt Programs			
-748,780	0	-748,780	Net Final Settlements	-332,421	-416,359	-748,780
85,105,816	3,748,129	88,853,945	Net Accounts Receivables	71,953,885	16,900,060	88,853,945
19,867,372	-2,172,888	17,694,484	Inventories	17,452,642	241,842	17,694,484
1,028,186	268,979	1,297,165	Prepaid Expenses	6,150,179	-4,853,014	1,297,165
506,348	20,852	527,200	Other Receivables	59,212	467,988	527,200
106,604,869	1,835,339	108,440,208	Total Current Assets	95,699,232	12,740,976	108,440,208
			PROPERTY, PLANT & EQUIPMENT			
25,916,826	0	25,916,826	Land	25,916,826	0	25,916,826
212,212,129	739,959	212,952,088	Bldgs & Improvements	212,579,302	372,786	212,952,088
274,026,594	-404,209	273,622,385	Equipment - Owned	256,888,958	16,733,427	273,622,385
3,696,144	0	3,696,144	Equipment - Capital Leases	1,918,430	1,777,714	3,696,144
296,866	290,676	587,542	Construction in Progress	274,022	313,520	587,542
516,148,559	626,426	516,774,985	Gross PP&E	497,577,538	19,197,447	516,774,985
-288,614,758	-1,873,595	-290,488,353	Less Accumulated Depreciation	-257,930,489	-32,557,864	-290,488,353
227,533,801	-1,247,169	226,286,632	Net PP&E	239,647,049	-13,360,417	226,286,632
			OTHER ASSETS			
			Investments			
20,700	0	20,700	Notes Receivable	21,250	-550	20,700
45,813,544	0	45,813,544	Intangible Assets - Net	45,813,544	0	45,813,544
			Investments in Subsidiaries			
			Other Assets			
45,834,244	0	45,834,244	Total Other Assets	45,834,794	-550	45,834,244
379,972,914	588,170	380,561,084	Grand Total Assets	381,181,075	-619,991	380,561,084
			CURRENT LIABILITIES			
16,831,389	-645,562	16,185,827	Accounts Payable	17,460,537	-1,274,754	16,185,783
12,778,859	1,248,521	14,027,380	Accrued Salaries	13,091,541	935,839	14,027,380
5,572,048	-144,570	5,427,478	Accrued Expenses	5,490,127	-62,649	5,427,478
			Accrued Interest			
			Distributions Payable			
620,852	3,210	624,062	Curr Port - Long Term Debt	325,823	298,239	624,062
79,736	3,598	83,334	Other Current Liabilities	50,983	32,351	83,334
			Income Taxes Payable			
35,882,884	465,197	36,348,081	Total Current Liabilities	36,419,011	-70,974	36,348,037
			LONG TERM DEBT			
2,123,171	-59,601	2,063,570	Capitalized Leases	1,084,112	979,458	2,063,570
-413,478,269	-8,071,871	-421,550,140	Inter/Intra Company Debt	-356,759,221	-64,790,919	-421,550,140
15,319,891	0	15,319,891	Other Long Term Debts	15,319,891	0	15,319,891
-396,035,207	-8,131,472	-404,166,679	Total Long Term Debts	-340,355,218	-63,811,461	-404,166,679
			DEFFERED CREDITS AND OTHER LIAB			
			Professional Liab Risk			
			Deferred Incomes Taxes			
233,499	-1,534	231,965	Long-Term Obligations	278,897	-46,932	231,965
233,499	-1,534	231,965	Total Other Liabilities & Def	278,897	-46,932	231,965
			EQUITY			
			Common Stock - par value			
142,871,513	0	142,871,513	Capital in Excess of par value	142,871,513	0	142,871,513
510,882,746	0	510,882,746	Retained Earnings - current yr	605,276,243	0	605,276,243
86,137,479	8,255,979	94,393,458	Net Income Current Year			
			Distributions			
			Other Equity			
739,891,738	8,255,979	748,147,717	Total Equity	684,838,385	63,309,376	748,147,761
379,972,914	588,170	380,561,084	Total Liabilities and Equity	381,181,075	-619,991	380,561,084

Z00001 - Centennial Medical Center

Dec - 2013

All Entities

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Report ID: ALCFS008

Financial Statements - Income Statement

Month							All Department Num	Year to Date						
Actual	Budget	Bud Var	Var %	Prior Year	PY Var	Var %		Actual	Budget	Bud Var	Var %	Prior Year	PY Var	Var %
							REVENUES							
33,960	30,926	3,035	9.81%	31,534	2,426	7.69%	Inpatient Revenue Routine Services	386,832	357,599	29,233	8.17%	320,886	65,946	20.55%
114,246	114,325	(80)	-0.07%	104,052	10,194	9.80%	Inpatient Revenue Ancillary Services	1,258,243	1,285,551	(27,307)	-2.12%	1,132,512	125,731	11.10%
148,206	145,251	2,955	2.03%	135,586	12,621	9.31%	Inpatient Gross Revenue	1,645,075	1,643,150	1,926	0.12%	1,453,399	191,677	13.19%
79,796	70,282	9,514	13.54%	58,938	20,858	35.39%	Outpatient Gross Revenue	838,010	848,514	(10,504)	-1.24%	727,819	110,191	15.14%
228,002	215,533	12,469	5.79%	194,524	33,479	17.21%	Total Patient Revenue	2,483,085	2,491,663	(8,578)	-0.34%	2,181,217	301,867	13.84%
258	272	(14)	-5.23%	248	9	3.79%	Other Revenue	3,568	3,426	142	4.14%	3,290	278	8.44%
228,260	215,805	12,455	5.77%	194,772	33,488	17.19%	Gross Revenue	2,486,653	2,495,089	(8,437)	-0.34%	2,184,508	302,145	13.83%
							DEDUCTIONS							
54,554	58,672	(4,118)	-7.02%	49,968	4,586	9.18%	Total CY CA - Medicare (1,2)	634,764	674,787	(40,022)	-5.93%	586,278	48,486	8.27%
404	55	349	639.25%	89	315	353.73%	Total CY CA - Medicaid (3)	3,238	602	2,637	438.29%	1,166	2,072	177.73%
2,791	2,846	(55)	-1.94%	2,922	(131)	-4.48%	Total CY CA - Champus (6)	35,530	32,206	3,323	10.32%	29,028	6,502	22.40%
				(3,476)	3,476	100.00%	Prior Year Contractuals	(2,620)	(3,025)	405	13.39%	(6,409)	3,790	59.13%
97,998	90,779	7,219	7.95%	79,676	18,322	23.00%	Total CY CA - Mgd Care (7,8,9,12,13,14)	1,065,724	1,051,222	14,502	1.38%	893,908	171,816	19.22%
(1,052)	1,696	(2,749)	-162.04%	554	(1,606)	-290.08%	Charity	12,779	19,604	(6,825)	-34.81%	15,794	(3,014)	-19.09%
7,227	2,331	4,896	210.04%	4,341	2,886	66.47%	Bad Debt	20,819	49,965	(29,146)	-58.33%	38,456	(17,637)	-45.86%
17,722	12,104	5,618	46.42%	12,059	5,663	46.96%	Other Deductions	168,033	138,782	29,251	21.08%	118,775	49,258	41.47%
179,644	168,484	11,160	6.62%	146,133	33,511	22.93%	Total Revenue Deductions (Incl Bad Debt)	1,938,268	1,964,143	(25,875)	-1.32%	1,676,995	261,272	15.58%
48,616	47,322	1,295	2.74%	48,639	(23)	-0.05%	Cash Revenue	548,385	530,946	17,439	3.28%	507,513	40,873	8.05%
							OPERATING EXPENSES							
12,371	12,988	(617)	-4.75%	12,011	360	3.00%	Salaries and Wages	145,699	148,206	(2,507)	-1.69%	138,101	7,598	5.50%
544	306	238	77.83%	269	275	102.01%	Contract Labor	5,256	3,548	1,708	48.12%	4,655	601	12.91%
2,598	3,069	(471)	-15.33%	2,959	(360)	-12.18%	Employee Benefits	38,622	41,109	(2,486)	-6.05%	38,829	(206)	-0.53%
12,610	8,848	3,762	42.52%	8,308	4,302	51.79%	Supply Expense	115,666	108,921	6,745	6.19%	105,525	10,141	9.61%
832	883	(50)	-5.71%	821	11	1.36%	Professional Fees	10,787	10,651	137	1.28%	8,410	2,377	28.27%
4,424	3,971	454	11.43%	4,629	(205)	-4.42%	Contract Services	49,426	48,119	1,308	2.72%	49,669	(243)	-0.49%
1,030	786	243	30.94%	838	192	22.91%	Repairs and Maintenance	10,290	9,452	837	8.86%	9,980	310	3.10%
653	620	33	5.33%	590	62	10.59%	Rents and Leases	7,448	7,404	43	0.59%	7,734	(286)	-3.69%
436	488	(51)	-10.56%	481	(45)	-9.28%	Utilities	6,019	6,171	(152)	-2.47%	5,934	85	1.43%
(222)	(225)	3	1.50%	(82)	(140)	-171.91%	Insurance	2,587	2,575	12	0.46%	3,131	(544)	-17.39%
							Investment Income							
(180)	386	(567)	-146.66%	627	(808)	-128.74%	Non-Income Taxes	4,587	4,637	(50)	-1.08%	4,162	425	10.21%
766	526	240	45.57%	630	136	21.59%	Other Operating Expense	7,134	6,011	1,122	18.67%	6,169	964	15.63%
35,864	32,646	3,218	9.86%	32,081	3,782	11.79%	Cash Expense	403,521	396,806	6,715	1.69%	382,299	21,222	5.55%
12,753	14,676	(1,923)	-13.10%	16,558	(3,805)	-22.98%	EBITDA	144,864	134,141	10,723	7.99%	125,213	19,651	15.69%
							CAPITAL AND OTHER COSTS							
2,519	2,194	325	14.80%	2,411	108	4.46%	Depreciation & Amortization	32,789	26,825	5,963	22.23%	29,077	3,711	12.76%
							Other Non-Operating Expenses							
(1,687)	(1,280)	(407)	-31.83%	(1,385)	(303)	-21.85%	Interest Expense	(17,841)	(15,608)	(2,233)	-14.31%	(15,163)	(2,678)	-17.66%
3,665	3,610	55	1.53%	(3,625)	7,290	201.10%	Mgmt Fees and Markup Cost	35,523	43,466	(7,942)	-18.27%	29,701	5,823	19.60%
							Minority Interest							
4,497	4,524	(27)	-0.61%	(2,598)	7,095	273.08%	Total Capital and Others	50,471	54,683	(4,212)	-7.70%	43,615	6,856	15.72%
8,256	10,152	(1,896)	-18.67%	19,156	(10,900)	-56.90%	Pretax Income	94,393	79,458	14,936	18.80%	81,599	12,795	15.68%
							TAXES ON INCOME							
							Federal Income Taxes							
							State Income Taxes							
							Total Taxes on Income							
8,256	10,152	(1,896)	-18.67%	19,156	(10,900)	-56.90%	Net Income	94,393	79,458	14,936	18.80%	81,599	12,795	15.68%

C, Orderly Development--7(C)
Licensing & Accreditation Inspections

The Joint Commission

TriStar Centennial Medical Center
2300 Patterson Street
Nashville, TN 37203

Organization Identification Number: 7888

Program(s)	**Survey Date(s)**
Hospital Accreditation Critical Access Hospital Accreditation	11/04/2013-11/08/2013

Executive Summary

Hospital Accreditation :

As a result of the accreditation activity conducted on the above date(s), you have met the criteria for Accreditation with Follow-up Survey.

If your organization wishes to clarify any of the standards you believe were compliant at the time of survey, you may submit clarifying Evidence of Standards Compliance in 10 business days from the day this report is posted to your organization's extranet site.

You will have follow-up in the area(s) indicated below:

- As a result of a Condition Level Deficiency, an Unannounced Medicare Deficiency Follow-up Survey will occur. Please address and correct any Condition Level Deficiencies immediately, as the follow-up event addressing these deficiencies will occur within 45 days of the last survey date identified above. The follow-up event is in addition to the written Evidence of Standards Compliance response.
- Evidence of Standards Compliance (ESC)

Critical Access Hospital Accreditation :

As a result of the accreditation activity conducted on the above date(s), you have met the criteria for Accreditation with Follow-up Survey.

If your organization wishes to clarify any of the standards you believe were compliant at the time of survey, you may submit clarifying Evidence of Standards Compliance in 10 business days from the day this report is posted to your organization's extranet site.

You will have follow-up in the area(s) indicated below:

- Evidence of Standards Compliance (ESC)
- As a result of a Condition Level Deficiency, an Unannounced Medicare Deficiency Follow-up Survey will occur. Please address and correct any Condition Level Deficiencies immediately, as the follow-up event addressing these deficiencies will occur within 45 days of the last survey date identified above. The follow-up event is in addition to the written Evidence of Standards Compliance response.

If you have any questions, please do not hesitate to contact your Account Executive.

Thank you for collaborating with The Joint Commission to improve the safety and quality of care provided to patients.

The Joint Commission
Summary of Findings

Evidence of DIRECT Impact Standards Compliance is due within 45 days from the day the survey report was originally posted to your organization's extranet site:

Program:	Hospital Accreditation Program	
Standards:	EC.02.02.01	EP5,EP7,EP12
	EC.02.03.01	EP1
	EC.02.03.05	EP3,EP4
	EC.02.05.01	EP1,EP6,EP8
	IC.02.01.01	EP3
	IC.02.02.01	EP1,EP2,EP4
	LD.03.06.01	EP3
	LS.01.01.01	EP2
	MM.03.01.01	EP2,EP7,EP8
	NPSG.01.01.01	EP1
	PC.03.05.05	EP6
	PC.03.05.11	EP1,EP3
	RC.02.01.03	EP6
Program:	Critical Access Hospital Accreditation Program	
Standards:	EC.02.05.09	EP1,EP3
	LS.02.01.10	EP1,EP4

Evidence of INDIRECT Impact Standards Compliance is due within 60 days from the day the survey report was originally posted to your organization's extranet site:

Program:	Hospital Accreditation Program	
Standards:	APR.01.03.01	EP1
	EC.02.04.03	EP3
	EC.02.06.01	EP1,EP13
	HR.01.04.01	EP7
	LD.01.03.01	EP2
	LD.04.03.09	EP6
	LS.02.01.10	EP3,EP5,EP9

The Joint Commission
Summary of Findings

Evidence of INDIRECT Impact Standards Compliance is due within 60 days from the day the survey report was originally posted to your organization's extranet site:

LS.02.01.20	EP31,EP32
LS.02.01.30	EP11,EP18
LS.02.01.34	EP4
LS.02.01.35	EP4,EP5,EP14
RC.01.01.01	EP19
RI.01.03.01	EP13
UP.01.03.01	EP2

CoP: §485.623 **Tag:** C-0220 **Deficiency:** Condition

Corresponds to: CAH

Text: §485.623 Condition of Participation: Physical Plant and Environment

CoP Standard	Tag	Corresponds to	Deficiency
§485.623(d)(1)	C-0231	CAH - LS.02.01.10/EP1, EP4	Standard
§485.623(b)(1)	C-0222	CAH - EC.02.05.09/EP1	Standard

CoP: §482.13 **Tag:** A-0115 **Deficiency:** Standard

Corresponds to: HAP

Text: §482.13 Condition of Participation: Patient's Rights

A hospital must protect and promote each patient's rights.

CoP Standard	Tag	Corresponds to	Deficiency
§482.13(e)(12)(ii)(C)	A-0179	HAP - PC.03.05.11/EP3	Standard
§482.13(e)(14)	A-0182	HAP - PC.03.05.11/EP1	Standard
§482.13(e)(8)(iii)	A-0173	HAP - PC.03.05.05/EP6	Standard

CoP: §482.23 **Tag:** A-0385 **Deficiency:** Standard

Corresponds to: HAP

Text: §482.23 Condition of Participation: Nursing Services

The hospital must have an organized nursing service that provides 24-hour nursing services. The nursing services must be furnished or supervised by a registered nurse.

CoP Standard	Tag	Corresponds to	Deficiency
§482.23(b)(6)	A-0398	HAP - LD.04.03.09/EP6	Standard

CoP: §482.24 **Tag:** A-0431 **Deficiency:** Standard

Corresponds to: HAP

Text: §482.24 Condition of Participation: Medical Record Services

The hospital must have a medical record service that has administrative responsibility for medical records. A medical record must be maintained for every individual evaluated or treated in the hospital.

CoP Standard	Tag	Corresponds to	Deficiency
§482.24(c)(1)	A-0450	HAP - RC.01.01.01/EP19	Standard

CoP: §482.25 **Tag:** A-0490 **Deficiency:** Standard

Corresponds to: HAP

Text: §482.25 Condition of Participation: Pharmaceutical Services

The hospital must have pharmaceutical services that meet the needs of the patients. The institution must have a pharmacy directed by a registered pharmacist or a drug storage area under competent supervision. The medical staff is responsible for developing policies and procedures that minimize drug errors. This function may be delegated to the hospital's organized pharmaceutical service.

CoP Standard	Tag	Corresponds to	Deficiency
§482.25(b)(3)	A-0505	HAP - MM.03.01.01/EP8	Standard

CoP: §482.26 **Tag:** A-0528 **Deficiency:** Standard

Corresponds to: HAP

Text: §482.26 Condition of Participation: Radiologic Services

The hospital must maintain, or have available, diagnostic radiologic services. If therapeutic services are also provided, they, as well as the diagnostic services, must meet professionally approved standards for safety and personnel qualifications.

CoP Standard	Tag	Corresponds to	Deficiency
§482.26(b)(1)	A-0536	HAP - EC.02.02.01/EP7	Standard

CoP: §482.41 **Tag:** A-0700 **Deficiency:** Condition

Corresponds to: HAP

Text: §482.41 Condition of Participation: Physical Environment

The hospital must be constructed, arranged, and maintained to ensure the safety of the patient, and to provide facilities for diagnosis and treatment and for special hospital services appropriate to the needs of the community.

CoP Standard	Tag	Corresponds to	Deficiency
§482.41(c)(2)	A-0724	HAP - EC.02.04.03/EP3, EC.02.06.01/EP1	Standard
§482.41(a)	A-0701	HAP - EC.02.06.01/EP1	Standard
§482.41(b)(1)(i)	A-0710	HAP - LS.01.01.01/EP2, EC.02.03.05/EP3, EP4, LS.02.01.10/EP3, EP5, EP9, LS.02.01.20/EP31, EP32, LS.02.01.30/EP11, EP18, LS.02.01.34/EP4, LS.02.01.35/EP4, EP5, EP14	Standard

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CoP: §482.42 **Tag:** A-0747 **Deficiency:** Condition

Corresponds to: HAP - EC.02.05.01/EP6, EC.02.06.01/EP13

Text: §482.42 Condition of Participation: Infection Control

The hospital must provide a sanitary environment to avoid sources and transmission of infections and communicable diseases. There must be an active program for the prevention, control, and investigation of infections and communicable diseases.

CoP: §482.51 **Tag:** A-0940 **Deficiency:** Standard

Corresponds to: HAP

Text: §482.51 Condition of Participation: Surgical Services

If the hospital provides surgical services, the services must be well organized and provided in accordance with acceptable standards of practice. If outpatient surgical services are offered the services must be consistent in quality with inpatient care in accordance with the complexity of services offered.

CoP Standard	Tag	Corresponds to	Deficiency
§482.51(b)	A-0951	HAP - IC.02.02.01/EP1, EP2, EP4	Standard
§482.51(b)(6)	A-0959	HAP - RC.02.01.03/EP6	Standard

CoP: §482.56 **Tag:** A-1123 **Deficiency:** Standard

Corresponds to: HAP

Text: §482.56 Condition of Participation: Rehabilitation Services

If the hospital provides rehabilitation, physical therapy, occupational therapy, audiology, or speech pathology services, the services must be organized and staffed to ensure the health and safety of patients.

CoP Standard	Tag	Corresponds to	Deficiency
§482.56(a)	A-1124	HAP - LD.03.06.01/EP3	Standard

CoP: §482.12 **Tag:** A-0043 **Deficiency:** Condition

Corresponds to: HAP - LD.01.03.01/EP2

Text: §482.12 Condition of Participation: Governing Body

There must be an effective governing body that is legally responsible for the conduct of the hospital. If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this part that pertain to the governing body. The governing body (or the persons legally responsible for the conduct of the hospital and carrying out the functions specified in this part that pertain to the governing body) must include a member, or members, of the hospital's medical staff.

The Joint Commission
Findings

Chapter: Accreditation Participation Requirements

Program: Hospital Accreditation

Standard: APR.01.03.01 ESC 60 days

Standard Text: The hospital reports any changes in the information provided in the application for accreditation and any changes made between surveys.

Primary Priority Focus Area: Information Management

Element(s) of Performance:

1. The hospital notifies The Joint Commission in writing within 30 days of a change in ownership, control, location, capacity, or services offered.
Note: When the hospital changes ownership, control, location, capacity, or services offered, it may be necessary for The Joint Commission to survey the hospital again. If the hospital does not provide written notification to The Joint Commission within 30 days of these changes, the hospital could lose its accreditation.

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 1
Observed in Tracer Activities at TriStar Centennial Medical Center (2300 Patterson Street, Nashville, TN) site. During tracer activity, it was noted that the hospital operated an Intensive Outpatient Program. This program was not indicated on the hospital's Joint Commission application. Additionally, this program moved to a new site on June 24, 2013. The hospital had not provided written notification to the Joint Commission within 30 days of this change in location.

Chapter: Environment of Care

Program: Hospital Accreditation

Standard: EC.02.02.01 ESC 45 days

Standard Text: The hospital manages risks related to hazardous materials and waste.

Primary Priority Focus Area: Equipment Use

The Joint Commission
Findings

Element(s) of Performance:

5. The hospital minimizes risks associated with selecting, handling, storing, transporting, using, and disposing of hazardous chemicals. 

Scoring
Category : C
Score : Partial Compliance

7. The hospital minimizes risks associated with selecting and using hazardous energy sources. 
Note: Hazardous energy is produced by both ionizing equipment (for example, radiation and x-ray equipment) and nonionizing equipment (for example, lasers and MRIs).

Scoring
Category : A
Score : Insufficient Compliance

12. The hospital labels hazardous materials and waste. Labels identify the contents and hazard warnings. * 
Footnote *: The Occupational Safety and Health Administration's (OSHA) Bloodborne Pathogens and Hazard Communications Standards and the National Fire Protection Association (NFPA) provide details on labeling requirements.

Scoring
Category : A
Score : Insufficient Compliance

Observation(s):

The Joint Commission
Findings

EP 5
Observed in Building Tour at TriStar Centennial Medical Center (2300 Patterson Street, Nashville, TN) site.
During the building tour it was observed that the hospital did not minimize risks associated with handling, storing, and using, of hazardous chemicals.
It was observed that the eye wash station located in the boiler room was connected to cold water only and the hospital did not monitor the temperature and could not ensure that the water temperature was maintained tepid.

Observed in Building Tour at TriStar Centennial Medical Center (2300 Patterson Street, Nashville, TN) site.
During the building tour it was observed that the hospital did not minimize risks associated with handling, storing, and using, of hazardous chemicals.
It was observed that the eye wash station located in the chiller room was connected to cold water only and the hospital did not monitor the temperature and could not ensure that the water temperature was maintained tepid.

EP 7
§482.26(b)(1) - (A-0536) - (1) Proper safety precautions must be maintained against radiation hazards. This includes adequate shielding for patients, personnel, and facilities, as well as appropriate storage, use and disposal of radioactive materials.
This Standard is NOT MET as evidenced by:
Observed in Storage area within Room #1 Interventional Radiology at TriStar Centennial Medical Center (2300 Patterson Street, Nashville, TN) site for the Hospital deemed service.
During an individual patient tracer folded lead aprons were found in a supply room within the Interventional Radiology Room #1. Folding of lead aprons does not minimize risks associated with the potential cracking of the lead which allows for hazardous energy to penetrate the apron.

Observed in Interventional Radiology at TriStar Centennial Medical Center (2300 Patterson Street, Nashville, TN) site for the Hospital deemed service.
During an individual patient tracer multiple folded lead aprons were found in the control room area within the Interventional Radiology department. Folding of lead aprons does not minimize risks associated with the potential cracking of the lead which allows for hazardous energy to penetrate the apron.

EP 12
Observed in Tracer Activities at TriStar ER Spring Hill (3001 Reserve Boulevard, Spring Hill, TN) site.
There was a spray bottle with a pink liquid stored in the housekeeper's cart. This bottle did not have a label that indicated the contents or the hazard warnings. In discussion with housekeeping staff, it was reported that this liquid was a disinfectant agent.

Chapter: Environment of Care

Program: Hospital Accreditation

Standard: EC.02.03.01 ESC 45 days

Standard Text: The hospital manages fire risks.

Primary Priority Focus Area: Physical Environment

Element(s) of Performance:

1. The hospital minimizes the potential for harm from fire, smoke, and other products of combustion. 3

Scoring Category : C
Score : Insufficient Compliance

Observation(s):

The Joint Commission
Findings

EP 1
Observed in Building Tour at Centennial Medical Center Women's Hospital Blood Gas Lab (2221 Murphy Avenue, Nashville, TN) site.
During the building tour of the Women's and Children's hospital it was observed on the Plant Operations electrical room electrical panel #1 was open and the electrical wires were exposed due to the cover was not installed and therefore the hospital did not minimize the potential for harm from fire and smoke.

Observed in Building Tour at Centennial Medical Center Women's Hospital Blood Gas Lab (2221 Murphy Avenue, Nashville, TN) site.
During the building tour of the Women's and Children's hospital it was observed on the Plant Operations electrical room electrical panel #2 was open and the electrical wires were exposed due to the cover was not installed and therefore the hospital did not minimize the potential for harm from fire and smoke.

Observed in Building Tour at Centennial Medical Center Women's Hospital Blood Gas Lab (2221 Murphy Avenue, Nashville, TN) site.
During the building tour of the Women's and Children's hospital it was observed on the 1st floor above the ceiling, electrical junction box # 3 was open and cove plate was not properly installed and therefore the hospital did not minimize the potential for harm from fire and smoke.

Observed in Building Tour at Centennial Medical Center Women's Hospital Blood Gas Lab (2221 Murphy Avenue, Nashville, TN) site.
During the building tour of the Women's and Children's hospital it was observed in the 1st floor above the ceiling near the OB ED, electrical junction box # 4 was open and cove plate was not properly installed and therefore the hospital did not minimize the potential for harm from fire and smoke.

Chapter:	Environment of Care
Program:	Hospital Accreditation
Standard:	EC.02.03.05 ESC 45 days
Standard Text:	The hospital maintains fire safety equipment and fire safety building features. Note: This standard does not require hospitals to have the types of fire safety equipment and building features described below. However, if these types of equipment or features exist within the building, then the following maintenance, testing, and inspection requirements apply.
Primary Priority Focus Area:	Physical Environment

Element(s) of Performance:

3. Every 12 months, the hospital tests duct detectors, electromechanical releasing devices, heat detectors, manual fire alarm boxes, and smoke detectors. The completion date of the tests is documented.
Note: For additional guidance on performing tests, see NFPA 72, 1999 edition (Table 7-3.2).

Scoring Category : C
Score : Insufficient Compliance

4. Every 12 months, the hospital tests visual and audible fire alarms, including speakers. The completion date of the tests is documented.
Note: For additional guidance on performing tests, see NFPA 72, 1999 edition (Table 7-3.2).

Scoring Category : C
Score : Insufficient Compliance

Observation(s):

EP 3
§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to:
http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.
This Standard is NOT MET as evidenced by:
Observed in Document Review at TriStar Centennial Medical Center (2300 Patterson Street, Nashville, TN) site for the Hospital deemed service.
During the document review it was observed that the hospital did not test all of their fire alarm system smoke detector devices every 12 months.
The documentation identified that smoke detector 3-379 was tested during the annual fire alarm system testing in August 2013, but was not tested during the annual testing of the fire alarm system in August 2012.

Observed in Document Review at TriStar Centennial Medical Center (2300 Patterson Street, Nashville, TN) site for the Hospital deemed service.
During the document review it was observed that the hospital did not test all of their fire alarm system smoke detector devices every 12 months.
The documentation identified that smoke detector 3-64 was tested during the annual fire alarm system testing in August 2013, but was not tested during the annual testing of the fire alarm system in August 2012.

Observed in Document Review at TriStar Centennial Medical Center (2300 Patterson Street, Nashville, TN) site for the Hospital deemed service.
During the document review it was observed that the hospital did not test all of their fire alarm system smoke detector devices every 12 months.
The documentation identified that smoke detector 3-91 was tested during the annual fire alarm system testing in August 2013, but was not tested during the annual testing of the fire alarm system in August 2012.

Observed in Document Review at TriStar Centennial Medical Center (2300 Patterson Street, Nashville, TN) site for the Hospital deemed service.
During the document review it was observed that the hospital did not test all of their fire alarm system manual pull station devices every 12 months.
The documentation identified that manual pull station 3-63 was tested during the annual fire alarm system testing in August 2013, but was not tested during the annual testing of the fire alarm system in August 2012.

Observed in Document Review at TriStar Centennial Medical Center (2300 Patterson Street, Nashville, TN) site for the Hospital deemed service.
During the document review it was observed that the hospital did not test all of their fire alarm system manual pull station devices every 12 months.
The documentation identified that manual pull station 3-90 was tested during the annual fire alarm system testing in August 2013, but was not tested during the annual testing of the fire alarm system in August 2012.

EP 4
§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to:
http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.
This Standard is NOT MET as evidenced by:
Observed in Document Review at TriStar Centennial Medical Center (2300 Patterson Street, Nashville, TN) site for the Hospital deemed service.
During the document review it was observed that the hospital did not test all of their fire alarm system audio and visual alarm devices every 12 months.
The documentation identified that chime/strobe device by exit stair C of the women's and children's hospital was tested during the annual fire alarm system testing in February 2013, but was not tested during the annual testing of the fire alarm system in February 2012.

Observed in Document Review at TriStar Centennial Medical Center (2300 Patterson Street, Nashville, TN) site for the Hospital deemed service.
During the document review it was observed that the hospital did not test all of their fire alarm system audio and visual alarm devices every 12 months.
The documentation identified that the chime/strobe device south west of the waiting room of the women's and children's hospital was tested during the annual fire alarm system testing in February 2013, but was not tested during the annual testing of the fire alarm system in February 2012.

Observed in Document Review at TriStar Centennial Medical Center (2300 Patterson Street, Nashville, TN) site for the Hospital deemed service.
During the document review it was observed that the hospital did not test all of their fire alarm system audio and visual alarm devices every 12 months.
The documentation identified that the strobe device at the west corridor waiting area of the women's and children's hospital was tested during the annual fire alarm system testing in February 2013, but was not tested during the annual testing of the fire alarm system in February 2012.

Chapter: Environment of Care

Program: Hospital Accreditation

Standard: EC.02.04.03

ESC 60 days

Standard Text: The hospital inspects, tests, and maintains medical equipment.

Primary Priority Focus Area: Equipment Use

Element(s) of Performance:

3. The hospital inspects, tests, and maintains non–life-support equipment identified on the medical equipment inventory. These activities are documented. (See also EC.02.04.01, EPs 2-4 and PC.02.01.11, EP 2)

Scoring Category : C
Score : Partial Compliance

Observation(s):

The Joint Commission
Findings

EP 3
§482.41(c)(2) - (A-0724) - (2) Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality.
This Standard is NOT MET as evidenced by:
Observed in Tracer Activities at TriStar Centennial Medical Center (2300 Patterson Street, Nashville, TN) site for the Hospital deemed service.
Review of preventive maintenance history for Infusion Pump 012932 noted that the hospital inspected this piece of equipment on 12/23/2010 with the next inspection on 11/2/2012. Documentation reflected that they could not locate the equipment during the 2011 PM cycle. There was no documentation as to when this piece of equipment was located, put back into service and that the equipment was inspected at that time.

Observed in Tracer Activities at TriStar Centennial Medical Center (2300 Patterson Street, Nashville, TN) site for the Hospital deemed service.
Review of preventive maintenance history for Module, Infusion Pump 011427 noted that the hospital inspected this piece of equipment on 11/3/2011 with the next inspection on 12/11/2012. Hospital policy stated that this piece of equipment should be inspected annually.

Chapter:	Environment of Care
Program:	Hospital Accreditation
Standard:	EC.02.05.01 ESC 45 days
Standard Text:	The hospital manages risks associated with its utility systems.
Primary Priority Focus Area:	Physical Environment

The Joint Commission
Findings

Element(s) of Performance:

1. The hospital designs and installs utility systems that meet patient care and operational needs. (See also EC.02.06.05, EP 1)

Scoring
Category : A
Score : Insufficient Compliance

6. In areas designed to control airborne contaminants (such as biological agents, gases, fumes, dust), the ventilation system provides appropriate pressure relationships, air-exchange rates, and filtration efficiencies.
Note: Areas designed for control of airborne contaminants include spaces such as operating rooms, special procedure rooms, delivery rooms for patients diagnosed with or suspected of having airborne communicable diseases (for example, pulmonary or laryngeal tuberculosis), patients in 'protective environment' rooms (for example, those receiving bone marrow transplants), laboratories, pharmacies, and sterile supply rooms. For further information, see Guidelines for Design and Construction of Health Care Facilities, 2010 edition, administered by the Facility Guidelines Institute and published by the American Society for Healthcare Engineering (ASHE).

Scoring
Category : A
Score : Insufficient Compliance

8. The hospital labels utility system controls to facilitate partial or complete emergency shutdowns.

Scoring
Category : A
Score : Insufficient Compliance

Observation(s):

The Joint Commission
Findings

EP 1
Observed in Building Tour at Centennial Medical Center Women's Hospital Blood Gas Lab (2221 Murphy Avenue, Nashville, TN) site.
During the building tour it was observed in the Women's and Children's hospital the mechanical room located in the 4th floor penthouse was designed that the only was to enter and exit the mechanical room is an elevator and the mechanical room was not designed with an approved exit from the mechanical room during a fire emergency.

EP 6
§482.42 - (A-0747) - §482.42 Condition of Participation: Condition of Participation: Infection Control
This Condition is NOT MET as evidenced by:
Observed in Building Tour at TriStar Centennial Medical Center (2300 Patterson Street, Nashville, TN) site for the Hospital deemed service.
During the building tour it was observed in the sterile processing department of the Women's and Children's hospital, the hospital did not maintain the proper air exchange rates and pressure relationships between the dirty decontamination room and the clean central sterile room due to a section of the wall which separates the two rooms, have been removed.

EP 8
Observed in Building Tour at Centennial Medical Center Women's Hospital Blood Gas Lab (2221 Murphy Avenue, Nashville, TN) site.
During the building tour it was observed in the Women's and Children's Hospital, electrical breakers located in electrical panel ACLU was not properly labeled to
facilitate partial or complete emergency shutdowns.

Observed in Building Tour at Parthenon Pavilion (2401 Parman Street, Nashville, TN) site.
During the building tour of the Partheon Pavilion it was observed that the electrical breakers located in eletrical panel 2E was not properly labeled to facilitate partial or complete emergency shutdowns.

Chapter: Environment of Care

Program: Hospital Accreditation

Standard: EC.02.06.01 ESC 60 days

Standard Text: The hospital establishes and maintains a safe, functional environment.
Note: The environment is constructed, arranged, and maintained to foster patient safety, provide facilities for diagnosis and treatment, and provide for special services appropriate to the needs of the community.

Primary Priority Focus Area: Physical Environment

Element(s) of Performance:

1. Interior spaces meet the needs of the patient population and are safe and suitable to the care, treatment, and services provided. 4

Scoring Category : C
Score : Insufficient Compliance

13. The hospital maintains ventilation, temperature, and humidity levels suitable for the care, treatment, and services provided. 4

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 1
§482.41(c)(2) - (A-0724) - (2) Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality.
This Standard is NOT MET as evidenced by:
Observed in Tracer Activities at Parthenon Pavilion (2401 Parman Street, Nashville, TN) site for the Hospital deemed service.
It was noted that on the geriatric unit, an isolation cart was stored next to a patient's room. This cart was not locked and contained items such as: red plastic biohazard trash bags, plastic isolation gowns, and gloves.

Observed in Tracer Activities at Parthenon Pavilion (2401 Parman Street, Nashville, TN) site for the Hospital deemed service.
It was noted that a picture hanging on the wall was not secured.

Observed in Tracer Activities at Parthenon Pavilion (2401 Parman Street, Nashville, TN) site for the Hospital deemed service.
During a tour of the unit, it was noted that there were large plastic trash bags in trash cans in the patient areas.

Observed in Tracer Activities at TriStar Centennial Medical Center (2300 Patterson Street, Nashville, TN) site for the Hospital deemed service.
During a tour of the unit, it was noted that one of the bathrooms in the patient room had a hand held shower with a hose which could pose a strangulation risk. This had not been identified as a risk so that mitigation strategies could be implemented.

Observed in Tracer Activities at TriStar Centennial Medical Center (2300 Patterson Street, Nashville, TN) site for the Hospital deemed service.
During a tour of the Sarah Cannon operating room, a stored e-cylinder was noted to be unsecured.

Observed in Tracer Activities at TriStar Centennial Medical Center (2300 Patterson Street, Nashville, TN) site for the Hospital deemed service.
During a tour of the Sarah Cannon operating room, it was noted that full and empty oxygen tanks were intermingled in the storage area. Additionally, it was noted that for storage of some of the oxygen tanks, there was no indication if they were full or empty.

§482.41(a) - (A-0701) - §482.41(a) Standard: Buildings

The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and well-being of patients are assured.
This Standard is NOT MET as evidenced by:
Observed in Building Tour at Centennial Medical Center Women's Hospital Blood Gas Lab (2221 Murphy Avenue, Nashville, TN) site for the Hospital deemed service.
During the building tour it was observed that the hospital did not identify the safety risk located in the Women's and Children's hospital on the 4th floor penthouse mechanical room. The hospital did not have an approved exit out of the mechanical room in a fire or other hazardous emergency.
The mechanical room had an elevator and access to the roof, but there was not an exit off the roof.

Observed in Building Tour at TriStar Centennial Medical Center (2300 Patterson Street, Nashville, TN) site for the Hospital deemed service.
During the building tour it was observed in the corridor of the 9th floor near the emergency helicopter entrance of Tower building, an empty oxygen e-cylinder # 1 was stored and there was no label or sign identifying that the cylinder was empty.

Observed in Building Tour at TriStar Centennial Medical Center (2300 Patterson Street, Nashville, TN) site for the Hospital deemed service.
During the building tour it was observed in the corridor of the 9th floor near the emergency helicopter entrance of Tower building,
an empty oxygen e-cylinder # 2 was stored and there was no label or sign identifying that the cylinder was empty.

The Joint Commission
Findings

EP 13
§482.42 - (A-0747) - §482.42 Condition of Participation: Condition of Participation: Infection Control
This Condition is NOT MET as evidenced by:
Observed in Central Sterile Processing Department at TriStar Centennial Medical Center (2300 Patterson Street, Nashville, TN) site for the Hospital deemed service.
During a tour of the Central Sterile Processing area the door leading from the surgical pack prep area and the sterilization of instruments area was found propped open with a door stopper. Room temperature and humidity cannot be adequately maintained according to AAMI standards in the surgical prep pack area if the door to the sterilization area that gets very warm and humid during the sterilization process is propped open.

Observed in Womens and Children Operating Room Department at TriStar Centennial Medical Center (2300 Patterson Street, Nashville, TN) site for the Hospital deemed service.
During tracer activities it was noted that the substerile room door leading out to the OR core hallway was found open. Sterilization had just occurred and the room was found to be warm and very humid. The door being open did not allow for appropriate temperature and humidity levels to be maintained.

Chapter: Human Resources

Program: Hospital Accreditation

Standard: HR.01.04.01 ESC 60 days

Standard Text: The hospital provides orientation to staff.

Primary Priority Focus Area: Orientation & Training

Element(s) of Performance:

7. The hospital orients external law enforcement and security personnel on the following:
- How to interact with patients
- Procedures for responding to unusual clinical events and incidents
- The hospital's channels of clinical, security, and administrative communication
- Distinctions between administrative and clinical seclusion and restraint

Scoring Category : C
Score : Partial Compliance

Observation(s):

EP 7
Observed in Tracer Activities at TriStar Centennial Medical Center (2300 Patterson Street, Nashville, TN) site.
In discussion with an external law enforcement officer who was sitting with a patient, he stated that he had not received an orientation or education in regards to how to interact with patient, procedures for responding to unusual clinical events and incidents, the hospital's channels of clinical, security, and administrative communication or distinctions between administrative and clinical seclusion and restraint. The officer stated that the only education he received was his specific department protocols.

Observed in Tracer Activities at TriStar Centennial Medical Center (2300 Patterson Street, Nashville, TN) site.
In discussion with a second external law enforcement officer who was sitting with a patient, he stated that he had not received an orientation or education in regards to how to interact with patient, procedures for responding to unusual clinical events and incidents, the hospital's channels of clinical, security, and administrative communication or distinctions between administrative and clinical seclusion and restraint. The officer stated that the only education he received was his specific department protocols.

The Joint Commission
Findings

Chapter: Infection Prevention and Control

Program: Hospital Accreditation

Standard: IC.02.01.01 ESC 45 days

Standard Text: The hospital implements its infection prevention and control plan.

Primary Priority Focus Area: Infection Control

Element(s) of Performance:

3. The hospital implements transmission-based precautions * in response to the pathogens that are suspected or identified within the hospital's service setting and community. 3
Note: Transmission-based precautions are infection prevention and control measures to protect against exposure to a suspected or identified pathogen. These precautions are specific and based on the way the pathogen is transmitted. Categories include contact, droplet, airborne, or a combination of these precautions.
Footnote *: For further information regarding transmission-based precautions, refer to the website of the Centers for Disease Control and Prevention (CDC) at http://www.cdc.gov/hai/ (Infection Control in Healthcare Settings).

Scoring Category : C
Score : Partial Compliance

Observation(s):

EP 3
Observed in Tracer Activities at TriStar Centennial Medical Center (2300 Patterson Street, Nashville, TN) site.
In a tour of the ECT suite and in discussion with clinical staff and IC staff it was noted that this area did not have a process to ensure that cubicle curtains were cleaned following an infectious patients being treated in the cubicle.

Observed in Tracer Activities at TriStar Centennial Medical Center (2300 Patterson Street, Nashville, TN) site.
In a tour of the endoscopy suite and in discussion with clinical staff and IC staff it was noted that this area did not have a process to ensure that cubicle curtains were cleaned following an infectious patients being treated in the cubicle.

Chapter: Infection Prevention and Control

Program: Hospital Accreditation

Standard: IC.02.02.01 ESC 45 days

Standard Text: The hospital reduces the risk of infections associated with medical equipment, devices, and supplies.

Primary Priority Focus Area: Infection Control

The Joint Commission
Findings

Element(s) of Performance:

1. The hospital implements infection prevention and control activities when doing the following: Cleaning and performing low-level disinfection of medical equipment, devices, and supplies. *
Note: Low-level disinfection is used for items such as stethoscopes and blood glucose meters. Additional cleaning and disinfecting is required for medical equipment, devices, and supplies used by patients who are isolated as part of implementing transmission-based precautions.
Footnote *: For further information regarding cleaning and performing low-level disinfection of medical equipment, devices, and supplies, refer to the website of the Centers for Disease Control and Prevention (CDC) at http://www.cdc.gov/hai/ (Sterilization and Disinfection in Healthcare Settings).

Scoring
Category : C
Score : Partial Compliance

2. The hospital implements infection prevention and control activities when doing the following: Performing intermediate and high-level disinfection and sterilization of medical equipment, devices, and supplies. * (See also EC.02.04.03, EP 4)
Note: Sterilization is used for items such as implants and surgical instruments. High-level disinfection may also be used if sterilization is not possible, as is the case with flexible endoscopes.
Footnote *: For further information regarding performing intermediate and high-level disinfection of medical equipment, devices, and supplies, refer to the website of the Centers for Disease Control and Prevention (CDC) at http://www.cdc.gov/hicpac/Disinfection_Sterilization/acknowledg.html (Sterilization and Disinfection in Healthcare Settings).

Scoring
Category : A
Score : Insufficient Compliance

4. The hospital implements infection prevention and control activities when doing the following: Storing medical equipment, devices, and supplies.

Scoring
Category : C
Score : Partial Compliance

Observation(s):

EP 1
§482.51(b) - (A-0951) - §482.51(b) Standard: Delivery of Service

Surgical services must be consistent with needs and resources. Policies governing surgical care must be designed to assure the achievement and maintenance of high standards of medical practice and patient care.
This Standard is NOT MET as evidenced by:
Observed in Tracer Activities at Parthenon Pavilion (2401 Parman Street, Nashville, TN) site for the Hospital deemed service.
It was noted that on the TICU, blood pressure cuffs intended for single patient use were being used on multiple patients.

Observed in Tracer Activities at Parthenon Pavilion (2401 Parman Street, Nashville, TN) site for the Hospital deemed service.
During a tour of the unit a soiled, single patient use blood pressure cuff was noted to be connected to the blood pressure machine as ready for use. In discussion with staff, there was no evidence that the unit had a defined process for the cleaning of blood pressure cuffs between patient use. It was initially reported that each patient was given an individual blood pressure cuff, however, there was no name identified on the soiled cuff. There were additional single patient use cuffs stored on the blood pressure machines however staff were not able to speak to whom these cuffs belonged. It was also reported that a blood pressure cuff was used for each patient and then discarded after use. A third staff member reported that the cuffs were cleaned after each patient use.

EP 2
§482.51(b) - (A-0951) - §482.51(b) Standard: Delivery of Service

Surgical services must be consistent with needs and resources. Policies governing surgical care must be designed to assure the achievement and maintenance of high standards of medical practice and patient care.
This Standard is NOT MET as evidenced by:
Observed in Labor and Delivery - 8th floor at TriStar Centennial Medical Center (2300 Patterson Street, Nashville, TN) site for the Hospital deemed service.
During an individual patient tracer, multiple instruments that had been packaged with the inner pouch folded were found being stored in the instrument storage area on the 8th floor and available for patient use.

Observed in Central Sterile Processing area at TriStar Centennial Medical Center (2300 Patterson Street, Nashville, TN) site for the Hospital deemed service.
During an individual patient tracer, multiple instruments that had been packaged with the inner pouch folded were found being stored in the instrument storage area in the Central Sterile processing area.

EP 4
§482.51(b) - (A-0951) - §482.51(b) Standard: Delivery of Service

Surgical services must be consistent with needs and resources. Policies governing surgical care must be designed to assure the achievement and maintenance of high standards of medical practice and patient care.
This Standard is NOT MET as evidenced by:
Observed in Tracer Activities at TriStar ER Spring Hill (3001 Reserve Boulevard, Spring Hill, TN) site for the Hospital deemed service.
It was noted that a transvaginal ultrasound probe was stored without a cover.

Observed in Interventional Radiology at TriStar Centennial Medical Center (2300 Patterson Street, Nashville, TN) site for the Hospital deemed service.
During tracer activities in the department a glass enclosed area was found storing sterile instrument packs and multiple sterile supplies such as interventional sterile radiologic catheters. There was a Hepa filter running in this room and one of the Hepa ports was allowing unfiltered air to flow directly onto the sterile instruments and supplies which did not allow for proper storage of medical devices and supplies. These supplies were discarded immediately by staff and this was corrected on site.

Chapter: Leadership

The Joint Commission
Findings

Program: Hospital Accreditation

Standard: LD.01.03.01 ESC 60 days

Standard Text: The governing body is ultimately accountable for the safety and quality of care, treatment, and services.

Primary Priority Focus Area: Communication

Element(s) of Performance:

2. The governing body provides for organization management and planning. 4

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 2
§482.12 - (A-0043) - §482.12 Condition of Participation: Condition of Participation: Governing Body
This Condition is NOT MET as evidenced by:
Observed in Auto Score for CLD at TriStar Centennial Medical Center (2300 Patterson Street, Nashville, TN) site.
The governing body/leadership did not ensure that the following Conditions of Participation were met as determined through observations, documentation, and staff interviews:§482.41 - (A-0700), §482.42 - (A-0747), §482.12 - (A-0043)

Chapter: Leadership

Program: Hospital Accreditation

Standard: LD.03.06.01 ESC 45 days

Standard Text: Those who work in the hospital are focused on improving safety and quality.

Primary Priority Focus Area: Staffing

Element(s) of Performance:

3. Leaders provide for a sufficient number and mix of individuals to support safe, quality care, treatment, and services. (See also IC.01.01.01, EP 3) 3
Note: The number and mix of individuals is appropriate to the scope and complexity of the services offered.

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

The Joint Commission
Findings

EP 3
§482.56(a) - (A-1124) - §482.56(a) Standard: Organization and Staffing

The organization of the service must be appropriate to the scope of the services offered.
This Standard is NOT MET as evidenced by:
Observed in the centralized dialysis treatment area at TriStar Centennial Medical Center (2300 Patterson Street, Nashville, TN) site for the Hospital deemed service.
During an individual patient tracer it was learned through interviews with dialysis staff and manager that on weekends they can and have performed dialysis in the dialysis treatment room with 1 RN on duty to care for a maximum number of two patients receiving dialysis. Review of the contracted service's policy states "at the discretion of the attending physician and if allowed by contractual agreement, the RN may care for up to two patients in a centralized treatment area alone if the patient's vital signs are stable...". Upon review of the contract between the hospital and the dialysis service it was noted that the contract did not address staffing nor state there was agreement for only one RN to care for up to two patients in a centralized treatment area alone if the patient's vital signs are stable.

Chapter: Leadership

Program: Hospital Accreditation

Standard: LD.04.03.09 ESC 60 days

Standard Text: Care, treatment, and services provided through contractual agreement are provided safely and effectively.

Primary Priority Focus Area: Organizational Structure

Element(s) of Performance:

6. Leaders monitor contracted services by evaluating these services in relation to the hospital's expectations. 

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 6
§482.23(b)(6) - (A-0398) - (6) Non-employee licensed nurses who are working in the hospital must adhere to the policies and procedures of the hospital. The director of nursing service must provide for the adequate supervision and evaluation of the clinical activities of non-employee nursing personnel which occur within the responsibility of the nursing services.
This Standard is NOT MET as evidenced by:
Observed in The Centralized Dialysis Treatment Area at TriStar Centennial Medical Center (2300 Patterson Street, Nashville, TN) site for the Hospital deemed service.
During an individual patient tracer it was learned through interviews with dialysis staff and manager that on weekends they can and have performed dialysis in the dialysis treatment room with 1 RN on duty to care for a maximum number of two patients receiving dialysis. Review of the contracted service's policy states "at the discretion of the attending physician and if allowed by contractual agreement, the RN may care for up to two patients in a centralized treatment area alone if the patient's vital signs are stable...". Upon review of the contract between the hospital and the dialysis service it was noted that the contract did not address staffing nor state there was agreement for only one RN to care for up to two patients in a centralized treatment area alone if the patient's vital signs are stable. It was further noted the hospital was unaware that this staffing pattern was in place in the centralized dialysis treatment area and had not evaluated this service in relation to maintaining appropriate levels of staff commensurate with agreed written contract.

The Joint Commission
Findings

Chapter: Life Safety

Program: Hospital Accreditation

Standard: LS.01.01.01 ESC 45 days

Standard Text: The hospital designs and manages the physical environment to comply with the Life Safety Code.

Primary Priority Focus Area: Physical Environment

Element(s) of Performance:

2. The hospital maintains a current electronic Statement of Conditions (E-SOC). 3
Note: The E-SOC is available to each hospital through The Joint Commission Connect™ extranet site.

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 2
§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.
This Standard is NOT MET as evidenced by:
Observed in Building Tour at TriStar Centennial Medical Center (2300 Patterson Street, Nashville, TN) site for the Hospital deemed service.
During the building tour and staff discussion it was observed that at time of survey the hospital did not have a current e -soc.
It was observed at time of survey that the hospital did not have a accurate set of life safety drawings. During the building tour it was observed that the hospital changed the use of the old cath lab rooms to storage rooms that were over 100 square ft and stored combustibles and other hazardous in the rooms and these rooms were not identified as hazardous areas on the life safety drawings. It was also observed at time of survey that the hospitals 's life safety drawing did not identify all of the occupancies and occupancy separations on the life safety drawings. It was observed that areas of the building were business occupancy and healthcare occupancy and these occupancies were not identified on the drawings as well as the separation of these areas.
It was also observed that the life safety drawing did not accurately identify the smoke wall separations of the Parkthenon Pavilion building.

Chapter: Life Safety

Program: Hospital Accreditation

Standard: LS.02.01.10 ESC 60 days

The Joint Commission
Findings

Standard Text: Building and fire protection features are designed and maintained to minimize the effects of fire, smoke, and heat.

Primary Priority Focus Area: Physical Environment

Element(s) of Performance:

3. Walls that are fire rated for 2 hours (such as common walls between buildings and occupancy separation walls within buildings) extend from the floor slab to the floor or roof slab above and extend from exterior wall to exterior wall. (For full text and any exceptions, refer to NFPA 101-2000: 8.2.2.2)

Scoring Category : A
Score : Insufficient Compliance

5. Doors required to be fire rated have functioning hardware, including positive latching devices and self-closing or automatic-closing devices. Gaps between meeting edges of door pairs are no more than 1/8 inch wide, and undercuts are no larger than 3/4 inch. (See also LS.02.01.30, EP 2; LS.02.01.34, EP 2) (For full text and any exceptions, refer to NFPA 101-2000: 8.2.3.2.3.1, 8.2.3.2.1 and NFPA 80-1999: 2-4.4.3, 2-3.1.7, and 1-11.4)

Scoring Category : C
Score : Partial Compliance

9. The space around pipes, conduits, bus ducts, cables, wires, air ducts, or pneumatic tubes that penetrate fire-rated walls and floors are protected with an approved fire-rated material.
Note: Polyurethane expanding foam is not an accepted fire-rated material for this purpose. (For full text and any exceptions, refer to NFPA 101-2000: 8.2.3.2.4.2)

Scoring Category : C
Score : Insufficient Compliance

Observation(s):

EP 3
§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to:
http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.
This Standard is NOT MET as evidenced by:
Observed in Building Tour at TriStar Centennial Medical Center (2300 Patterson Street, Nashville, TN) site for the Hospital deemed service.
During the building tour it was observed that the rating of the fire door located on the 2nd floor exit stair B of the Sara Canton building could not be verified due to the rating labeled was painted over.

EP 5
§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to:
http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.
This Standard is NOT MET as evidenced by:
Observed in Building Tour at TriStar Centennial Medical Center (2300 Patterson Street, Nashville, TN) site for the Hospital deemed service.
During the building tour it was observed that the exit fire door located in the basement of the Sara Cannon building in the Oncology until did not close and latch properly.

Observed in Building Tour at TriStar Centennial Medical Center (2300 Patterson Street, Nashville, TN) site for the Hospital deemed service.
During the building tour it was observed the the fire door located at the exit stair of the 3rd floor of the Sara Cannon building the fire door had greater than 1/8 gap between the door and door frame.

EP 9
§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to:
http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.
This Standard is NOT MET as evidenced by:
Observed in Building Tour at Centennial Medical Center Women's and Children's Hospital Blood Gas Lab

(2221 Murphy Avenue, Nashville, TN) site for the Hospital deemed service.
During the building tour it was observed in the Women's and Children's hospital the fire wall on the 2nd floor at east exit stair had a penetration that was not properly sealed.

Observed in Building Tour at Centennial Medical Center Women's and Children's Hospital Blood Gas Lab (2221 Murphy Avenue, Nashville, TN) site for the Hospital deemed service.
During the building tour it was observed in the Women's and Children's hospital the fire wall at the entrance to the OB ED, had a penetration that was not properly sealed.

Observed in Building Tour at Centennial Medical Center Women's and Children's Hospital Blood Gas Lab (2221 Murphy Avenue, Nashville, TN) site for the Hospital deemed service.
During the building tour it was observed in the Women's and Children's hospital the fire wall at the Kids Express had a penetration that was not properly sealed.

Chapter: Life Safety

Program: Hospital Accreditation

Standard: LS.02.01.20 ESC 60 days

Standard Text: The hospital maintains the integrity of the means of egress.

Primary Priority Focus Area: Physical Environment

Element(s) of Performance:

31. Exit signs are visible when the path to the exit is not readily apparent. Signs are adequately lit and have letters that are 4 or more inches high (or 6 inches high if externally lit). (For full text and any exceptions, refer to NFPA 101-2000: 7.10.1.2, 7.10.5, 7.10.6.1, and 7.10.7.1) 4

Scoring Category : C
Score : Insufficient Compliance

32. The hospital meets all other Life Safety Code means of egress requirements related to NFPA 101-2000: 18/19.2. 4

Scoring Category : C
Score : Insufficient Compliance

Observation(s):

EP 31
§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to:
http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.
This Standard is NOT MET as evidenced by:
Observed in Building Tour at Parthenon Pavilion (2401 Parman Street, Nashville, TN) site for the Hospital deemed service.
During the building tour it was observed in the Parthenon Pavilion an exit sign was missing in the locked courtyard,
and the exit to the public way was not readily apparent.

Observed in Building Tour at Parthenon Pavilion (2401 Parman Street, Nashville, TN) site for the Hospital deemed service.
During the building tour it was observed that an exit sign was missing and the path to the exit from the penthouse corridor was not readily
apparent in the Parthenon Pavilion building.

Observed in Building Tour at TriStar Centennial Medical Center (2300 Patterson Street, Nashville, TN) site for the Hospital deemed service.
During the building tour it was observed that an exit sign was missing in the kitchen. It was observed that the exit path was not readily apparent in the kitchen.

EP 32
§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to:
http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.
This Standard is NOT MET as evidenced by:
Observed in Building Tour at Centennial Medical Center Women's Hospital Blood Gas Lab (2221 Murphy Avenue, Nashville, TN) site for the Hospital deemed service.
During the building tour it was observed that the 4th floor penthouse mechanical room of the Women's and Children's hospital did not have an approved exit in the event of a fire emergency. The room has an elevator and roof access but there is not exit off the roof.

Observed in Building Tour at Centennial Medical Center Women's Hospital Blood Gas Lab (2221 Murphy Avenue, Nashville, TN) site for the Hospital deemed service.
During the building tour it was observed that the 4th floor penthouse mechanical room of the Women's and Children's hospital did not have an approved exit in the event of a fire emergency. The room has an elevator and roof access but there is not exit off the roof.

The Joint Commission
Findings

Observed in Building Tour at Centennial Medical Center Women's Hospital Blood Gas Lab (2221 Murphy Avenue, Nashville, TN) site for the Hospital deemed service.
During the building tour it was observed that the 4th floor penthouse mechanical room of the Women's and Children's hospital did not have an approved exit in the event of a fire emergency. The room has an elevator and roof access but there is not exit off the roof.

Chapter: Life Safety

Program: Hospital Accreditation

Standard: LS.02.01.30 ESC 60 days

Standard Text: The hospital provides and maintains building features to protect individuals from the hazards of fire and smoke.

Primary Priority Focus Area: Physical Environment

Element(s) of Performance:

11. Corridor doors are fitted with positive latching hardware, are arranged to restrict the movement of smoke, and are hinged so that they swing. The gap between meeting edges of door pairs is no wider than 1/8 inch, and undercuts are no larger than 1 inch. Roller latches are not acceptable.
Note: For existing doors, it is acceptable to use a device that keeps the door closed when a force of 5 foot-pounds are applied to the edge of the door. (For full text and any exceptions, refer to NFPA 101-2000: 18/19.3.6.3.2, 18/19.3.6.3.1, and 7.2.1.4.1)

Scoring Category : C
Score : Insufficient Compliance

18. Smoke barriers extend from the floor slab to the floor or roof slab above, through any concealed spaces (such as those above suspended ceilings and interstitial spaces), and extend continuously from exterior wall to exterior wall. All penetrations are properly sealed. (For full text and any exceptions, refer to NFPA 101-2000: 18/19.3.7.3)

Scoring Category : C
Score : Partial Compliance

Observation(s):

EP 11
§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to:
http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.
This Standard is NOT MET as evidenced by:
Observed in Building Tour at TriStar Centennial Medical Center (2300 Patterson Street, Nashville, TN) site for the Hospital deemed service.
During the building tour it was observed that the corridor doors entering the emergency department suite did not latch properly.

Observed in Building Tour at TriStar Centennial Medical Center (2300 Patterson Street, Nashville, TN) site for the Hospital deemed service.
During the building tour it was observed in the Tower building of the 7th floor the corridor doors had greater than 1/8 gap between the door pairs

Observed in Building Tour at TriStar Centennial Medical Center (2300 Patterson Street, Nashville, TN) site for the Hospital deemed service.
During the building tour it was observed in the Tower building of the 5th floor the corridor doors had greater than 1/8 gap between the door pairs

EP 18
§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to:
http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.
This Standard is NOT MET as evidenced by:
Observed in Building Tour at TriStar Centennial Medical Center (2300 Patterson Street, Nashville, TN) site for the Hospital deemed service.
During the building tour it was observed that smoke wall located in the Tower central sterile department and behind the sterilizers, had penetrations in the wall that were not properly sealed.

Observed in Building Tour at TriStar Centennial Medical Center (2300 Patterson Street, Nashville, TN) site for the Hospital deemed service.
During the building tour it was observed that the smoke wall located at the security office of the Tower building had a penetration that was not properly sealed.

Chapter: Life Safety

Program: Hospital Accreditation

The Joint Commission
Findings

Standard: LS.02.01.34 ESC 60 days

Standard Text: The hospital provides and maintains fire alarm systems.

Primary Priority Focus Area: Physical Environment

Element(s) of Performance:

4. The hospital meets all other Life Safety Code fire alarm requirements related to NFPA 101-2000: 18/19.3.4. 

Scoring Category : C
Score : Partial Compliance

Observation(s):

EP 4
§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.
This Standard is NOT MET as evidenced by:
Observed in Building Tour at TriStar Centennial Medical Center (2300 Patterson Street, Nashville, TN) site for the Hospital deemed service.
During the building tour it was observed that the manual fire alarm pull station located in the security department was blocked with equipment.

Observed in Building Tour at TriStar Centennial Medical Center (2300 Patterson Street, Nashville, TN) site for the Hospital deemed service.
During the building tour it was observed that the manual fire alarm pull station located in the pre - holding nurses station, was blocked with equipment.

Chapter: Life Safety

Program: Hospital Accreditation

Standard: LS.02.01.35 ESC 60 days

Standard Text: The hospital provides and maintains systems for extinguishing fires.

Primary Priority Focus Area: Physical Environment

The Joint Commission
Findings

Element(s) of Performance:

4. Piping for approved automatic sprinkler systems is not used to support any other item. (For full text and any exceptions, refer to NFPA 25-1998: 2-2.2)

Scoring
Category : C
Score : Insufficient Compliance

5. Sprinkler heads are not damaged and are free from corrosion, foreign materials, and paint. (For full text and any exceptions, refer to NFPA 25-1998: 2-2.1.1)

Scoring
Category : C
Score : Insufficient Compliance

14. The hospital meets all other Life Safety Code automatic extinguishing requirements related to NFPA 101-2000: 18/19.3.5.

Scoring
Category : C
Score : Partial Compliance

Observation(s):

EP 4
§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to:
http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.
This Standard is NOT MET as evidenced by:
Observed in Building Tour at Parthenon Pavilion (2401 Parman Street, Nashville, TN) site for the Hospital deemed service.
During the building tour it was observed in the Parkthenon Pavilion on the 4th floor the ceiling grid was tied to the sprinkler piping.

Observed in Building Tour at Parthenon Pavilion (2401 Parman Street, Nashville, TN) site for the Hospital deemed service.
During the building tour it was observed in the Parkthenon Pavilion on the 4th floor the cables were tied to the sprinkler piping.

Observed in Building Tour at Centennial Medical Center Women's Hospital Blood Gas Lab (2221 Murphy Avenue, Nashville, TN) site for the Hospital deemed service.
During the building tour it was observed in the women's and children's hospital it was observed that the sprinkler piping was supporting bundles of cables above the ceiling in the kids express unit.

EP 5
§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to:
http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.
This Standard is NOT MET as evidenced by:
Observed in Building Tour at TriStar Centennial Medical Center (2300 Patterson Street, Nashville, TN) site for the Hospital deemed service.
During the building tour of the penthouse mechanical room of the Tower building, it was observed that sprinkler head # 1 was not free from foreign materials.

Observed in Building Tour at TriStar Centennial Medical Center (2300 Patterson Street, Nashville, TN) site for the Hospital deemed service.
During the building tour of the penthouse mechanical room of the Tower building, it was observed that sprinkler head # 2 was not free from foreign materials.

Observed in Building Tour at TriStar Centennial Medical Center (2300 Patterson Street, Nashville, TN) site for the Hospital deemed service.
During the building tour of the penthouse mechanical room of the Tower building, it was observed that sprinkler head # 3 was not free from foreign materials.

The Joint Commission
Findings

EP 14
§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to:
http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.
This Standard is NOT MET as evidenced by:
Observed in Tracer Activities at Parthenon Pavilion (2401 Parman Street, Nashville, TN) site for the Hospital deemed service.
It was noted that the housekeeper did not have a key to the locked fire extinguisher.

Observed in Building Tour at TriStar Centennial Medical Center (2300 Patterson Street, Nashville, TN) site for the Hospital deemed service.
During the building tour of the Tower building it was observed that the ceiling smoke barrier located in the central sterile department had penetrations due to missing escutcheon rings on the sprinkler heads. It was also observed that missing escutcheon rings on the sprinkler heads were identified in several other areas of the Tower building.

Chapter:	Medication Management
Program:	Hospital Accreditation
Standard:	MM.03.01.01
Standard Text:	The hospital safely stores medications.
Primary Priority Focus Area:	Medication Management

ESC 45 days

The Joint Commission
Findings

Element(s) of Performance:

2. The hospital stores medications according to the manufacturers' recommendations or, in the absence of such recommendations, according to a pharmacist's instructions.

Scoring
Category : C
Score : Insufficient Compliance

7. All stored medications and the components used in their preparation are labeled with the contents, expiration date, and any applicable warnings.

Scoring
Category : C
Score : Insufficient Compliance

8. The hospital removes all expired, damaged, and/or contaminated medications and stores them separately from medications available for administration.

Scoring
Category : C
Score : Partial Compliance

Observation(s):

EP 2
Observed in Labor and Delivery room on 5th floor at TriStar Centennial Medical Center (2300 Patterson Street, Nashville, TN) site.
During an individual patient tracer and tour of the Labor and Delivery room on the 5th floor it was noted that a vial of Succinylcholine was being stored in a drawer in the anesthesia medication cart which was not refrigerated and was not dated with a date of when the medication was placed in the drawer. Manufacturer guidelines require that Succinylcholine may be stored up to 14 days without refrigeration, thus, one could not tell when the medication was placed in the drawer and when the medication should be discarded.

Observed in Labor and Delivery room on the 6th floor at TriStar Centennial Medical Center (2300 Patterson Street, Nashville, TN) site.
During an individual patient tracer and tour of the Labor and Delivery room on the 6th floor it was noted that a vial of Succinylcholine was being stored in a drawer in the anesthesia medication cart which was not refrigerated and was not dated with a date of when the medication was placed in the drawer. Manufacturer guidelines require that Succinylcholine may be stored up to 14 days without refrigeration, thus, one could not tell when the medication was placed in the drawer and when the medication should be discarded.

Observed in 8th floor Labor and Delivery Room at TriStar Centennial Medical Center (2300 Patterson Street, Nashville, TN) site.
During an individual patient tracer and tour of the Labor and Delivery room on the 8th floor it was noted that a vial of Succinylcholine was being stored in a drawer in the anesthesia medication cart which was not refrigerated and was not dated with a date of when the medication was placed in the drawer. Manufacturer guidelines require that Succinylcholine may be stored up to 14 days without refrigeration, thus, one could not tell when the medication was placed in the drawer and when the medication should be discarded.

Observed in Womens and Childrens OR at TriStar Centennial Medical Center (2300 Patterson Street, Nashville, TN) site.
During an individual patient tracer and tour of OR room #1 it was noted that a vial of Succinylcholine was being stored in a drawer in the anesthesia medication cart which was not refrigerated and was not dated with a date of when the medication was placed in the drawer. Manufacturer guidelines require that Succinylcholine may be stored up to 14 days without refrigeration, thus, one could not tell when the medication was placed in the drawer and when the medication should be discarded.

EP 7
Observed in Tracer Activities at Parthenon Pavilion (2401 Parman Street, Nashville, TN) site.
It was noted that an open multidose vial of purified protein derivative was dated with the open date. This vial was not labeled with the revised expiration date.

Observed in Tracer Activities at Parthenon Pavilion (2401 Parman Street, Nashville, TN) site.
It was noted that a multidose vial of Lantus was dated as opened on 10/24/13. The noted expiration date was 11/24/13, which is greater than 28 days beyond the date opened.

Observed in NICU Room 25 at TriStar Centennial Medical Center (2300 Patterson Street, Nashville, TN) site.
During an individual patient tracer a bag of sterile inhalation water was found attached to a ventilator in NICU room # 25. The bag of water had not been labeled with an expiration date. It was learned through interview with the staff respiratory therapist that all inhalation sterile water bags should be labeled with a 72 hour expiration date.

Observed in NICU Room #35 at TriStar Centennial Medical Center (2300 Patterson Street, Nashville, TN) site.
During an individual patient tracer a bag of sterile inhalation water was found attached to a ventilator in NICU room # 35. The bag of water had not been labeled with an expiration date. It was learned through interview with the staff respiratory therapist that all inhalation sterile water bags should be labeled with a 72 hour expiration date.

EP 8
§482.25(b)(3) - (A-0505) - (3) Outdated, mislabeled, or otherwise unusable drugs and biologicals must not be

available for patient use.
This Standard is NOT MET as evidenced by:
Observed in Labor and Delivery room 5th floor at TriStar Centennial Medical Center (2300 Patterson Street, Nashville, TN) site for the Hospital deemed service.
During an individual patient tracer two bags of Hespan IV that had expired in August of 2013 were found being stored in the anesthesia cart and available for patient use.

Observed in 8th floor Labor and Delivery room at TriStar Centennial Medical Center (2300 Patterson Street, Nashville, TN) site for the Hospital deemed service.
During an individual patient tracer one vial of Epinephrine IV that had expired in October of 2013 were found being stored in the anesthesia cart and available for patient use

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Chapter: National Patient Safety Goals

Program: Hospital Accreditation

Standard: NPSG.01.01.01 ESC 45 days

Standard Text: Use at least two patient identifiers when providing care, treatment, and services.

Primary Priority Focus Area: Patient Safety

Element(s) of Performance:

1. Use at least two patient identifiers when administering medications, blood, or blood components; when collecting blood samples and other specimens for clinical testing; and when providing treatments or procedures. The patient's room number or physical location is not used as an identifier. (See also MM.05.01.09, EPs 8 and 11; NPSG.01.03.01, EP 1) 3

Scoring Category : C
Score : Insufficient Compliance

Observation(s):

EP 1
Observed in Tracer Activities at Parthenon Pavilion (2401 Parman Street, Nashville, TN) site.
During a tour of the cafeteria and in discussion with staff, it was noted that the hospital did not have a process for the use of two patient identifiers when serving patients who were ordered a special diet.

Observed in Tracer Activities at Parthenon Pavilion (2401 Parman Street, Nashville, TN) site.
During observation of an Electroconvulsive Treatment, it was noted that the patient was identified utilizing only the patient's name. Hospital policy stated that verification of patient identification will be validated with the patient prior to any treatment, procedure, or medication by the staff member asking patient to state his/her name and birth date with comparison to the patients' arm band.

Observed in Tracer Activities at Parthenon Pavilion (2401 Parman Street, Nashville, TN) site.
During observation of a second Electroconvulsive Treatment, it was noted that the patient was identified utilizing only the patient's name.

Chapter: National Patient Safety Goals

Program: Hospital Accreditation

Standard: UP.01.03.01 ESC 60 days

The Joint Commission
Findings

Standard Text: A time-out is performed before the procedure.

Primary Priority Focus Area: Patient Safety

Element(s) of Performance:

2. The time-out has the following characteristics:
- It is standardized, as defined by the hospital.
- It is initiated by a designated member of the team.
- It involves the immediate members of the procedure team, including the individual performing the procedure, the anesthesia providers, the circulating nurse, the operating room technician, and other active participants who will be participating in the procedure from the beginning.

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 2
Observed in Tracer Activities at TriStar Centennial Medical Center (2300 Patterson Street, Nashville, TN) site.
A time out was observed in the inpatient endoscopy unit. It was noted that during this time out, the physician did not suspend activities to the extent possible so that she could focus on active confirmation of the patient, site, and procedure.

Chapter: Provision of Care, Treatment, and Services

Program: Hospital Accreditation

Standard: PC.03.05.05

ESC 45 days

Standard Text: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital initiates restraint or seclusion based on an individual order.

Primary Priority Focus Area: Assessment and Care/Services

Element(s) of Performance:

6. For hospitals that use Joint Commission accreditation for deemed status purposes: Orders for restraint used to protect the physical safety of the nonviolent or non–self-destructive patient are renewed in accordance with hospital policy.

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

The Joint Commission
Findings

EP 6
§482.13(e)(8)(iii) - (A-0173) - [Unless superseded by State law that is more restrictive --]

(iii) Each order for restraint used to ensure the physical safety of the non-violent or non-self-destructive patient may be renewed as authorized by hospital policy.
This Standard is NOT MET as evidenced by:
Observed in Tracer Activities at TriStar Centennial Medical Center (2300 Patterson Street, Nashville, TN) site for the Hospital deemed service.
The patient was ordered restraints on 11/2/13 at 2055 for a time period not to exceed 24 hours. The order for restraints was renewed on 11/3/13 at 2236, therefore were renewed after the order had expired.

Chapter:	Provision of Care, Treatment, and Services
Program:	Hospital Accreditation
Standard:	PC.03.05.11 ESC 45 days
Standard Text:	For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital evaluates and reevaluates the patient who is restrained or secluded.
Primary Priority Focus Area:	Assessment and Care/Services

The Joint Commission
Findings

Element(s) of Performance:

1. For hospitals that use Joint Commission accreditation for deemed status purposes: A physician, clinical psychologist, or other licensed independent practitioner responsible for the care of the patient evaluates the patient in-person within one hour of the initiation of restraint or seclusion used for the management of violent or self-destructive behavior that jeopardizes the physical safety of the patient, staff, or others. A registered nurse or a physician assistant may conduct the in-person evaluation within one hour of the initiation of restraint or seclusion; this individual is trained in accordance with the requirements in PC.03.05.17, EP 3.
Note 1: States may have statute or regulation requirements that are more restrictive than the requirements in this element of performance.
Note 2: The definition of 'physician' is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary).

Scoring Category : A
Score : Insufficient Compliance

3. For hospitals that use Joint Commission accreditation for deemed status purposes: The in-person evaluation, conducted within one hour of the initiation of restraint or seclusion for the management of violent or self-destructive behavior that jeopardizes the physical safety of the patient, staff, or others, includes the following:
- An evaluation of the patient's immediate situation
- The patient's reaction to the intervention
- The patient's medical and behavioral condition
- The need to continue or terminate the restraint or seclusion

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

The Joint Commission
Findings

EP 1
§482.13(e)(14) - (A-0182) - (14) If the face-to-face evaluation specified in paragraph (e)(12) of this section is conducted by a trained registered nurse or physician assistant, the trained registered nurse or physician assistant must consult the attending physician or other licensed independent practitioner who is responsible for the care of the patient as specified under §482.12(c) as soon as possible after the completion of the 1 hour face-to-face evaluation.
This Standard is NOT MET as evidenced by:
Observed in Tracer Activities at Parthenon Pavilion (2401 Parman Street, Nashville, TN) site for the Hospital deemed service.
The evaluation of the patient placed in seclusion for management of violent behavior was not signed, dated or timed. Therefore, it was not discernable that this had been completed by a licensed independent practitioner or that it had been completed within one hour of the initiation of seclusion.

EP 3
§482.13(e)(12)(ii)(C) - (A-0179) - (C) The patient's medical and behavioral condition; and
This Standard is NOT MET as evidenced by:
Observed in Tracer Activities at Parthenon Pavilion (2401 Parman Street, Nashville, TN) site for the Hospital deemed service.
In review of the record of care of a patient placed in seclusion, it was noted that the one hour face to face assessment did not include the patient's reaction to the intervention, the patient's medical condition or the need to continue the seclusion.

Observed in Tracer Activities at TriStar Centennial Medical Center (2300 Patterson Street, Nashville, TN) site for the Hospital deemed service.
In review of the record of care, it was noted that the in-person evaluation, conducted within one hour of seclusion for the management of violent behavior read: "patient agitated, nondirectable" This evaluation did not include the patient's reaction to the intervention,the patient's medical and behavioral condition, or the need to continue or terminate the restraint or seclusion.

Observed in Tracer Activities at TriStar Centennial Medical Center (2300 Patterson Street, Nashville, TN) site for the Hospital deemed service.
In review of the record of care, it was noted that the in-person evaluation, conducted within one hour of seclusion for the management of violent behavior read: "combative, danger to self & others, not following direction, psychotic" This evaluation did not include the patient's reaction to the intervention, the patient's medical condition, or the need to continue or terminate the restraint or seclusion.

Chapter: Record of Care, Treatment, and Services

Program: Hospital Accreditation

Standard: RC.01.01.01 ESC 60 days

Standard Text: The hospital maintains complete and accurate medical records for each individual patient.

Primary Priority Focus Area: Information Management

Element(s) of Performance:

19. For hospitals that use Joint Commission accreditation for deemed status purposes: All entries in the medical record, including all orders, are timed. 4

Scoring Category : C
Score : Insufficient Compliance

Observation(s):

The Joint Commission
Findings

EP 19
§482.24(c)(1) - (A-0450) - (1) All patient medical record entries must be legible, complete, dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided, consistent with hospital policies and procedures.
This Standard is NOT MET as evidenced by:
Observed in Tracer Activities at TriStar Centennial Medical Center (2300 Patterson Street, Nashville, TN) site for the Hospital deemed service.
In review of the record of care, it was noted that the post anesthesia assessment was not timed.

Observed in Tracer Activities at TriStar Centennial Medical Center (2300 Patterson Street, Nashville, TN) site for the Hospital deemed service.
While tracing a patient, entries in the record were noted to be untimed.

Observed in Tracer Activities at TriStar Centennial Medical Center (2300 Patterson Street, Nashville, TN) site for the Hospital deemed service.
While tracing another patient, it was noted that there were untimed entries.

Chapter: Record of Care, Treatment, and Services

Program: Hospital Accreditation

Standard: RC.02.01.03

ESC 45 days

Standard Text: The patient's medical record documents operative or other high-risk procedures and the use of moderate or deep sedation or anesthesia.

Primary Priority Focus Area: Information Management

Element(s) of Performance:

6. The operative or other high-risk procedure report includes the following information:
- The name(s) of the licensed independent practitioner(s) who performed the procedure and his or her assistant(s)
- The name of the procedure performed
- A description of the procedure
- Findings of the procedure
- Any estimated blood loss
- Any specimen(s) removed
- The postoperative diagnosis

3

Scoring Category : C
Score : Insufficient Compliance

Observation(s):

EP 6
§482.51(b)(6) - (A-0959) - (6) An operative report describing techniques, findings, and tissues removed or altered must be written or dictated immediately following surgery and signed by the surgeon.
This Standard is NOT MET as evidenced by:
Observed in Tracer Activities at TriStar Centennial Medical Center (2300 Patterson Street, Nashville, TN) site for the Hospital deemed service.
While tracing a patient who had open-heart surgery, it was noted that the practitioner failed to mention estimated blood loss in the operative report.

Observed in Tracer Activities at TriStar Centennial Medical Center (2300 Patterson Street, Nashville, TN) site for the Hospital deemed service.
While tracing a patient who had a cardiac catheterization, it was noted that the practitioner failed to document estimated blood loss in the procedure report.

Observed in Tracer Activities at TriStar Centennial Medical Center (2300 Patterson Street, Nashville, TN) site for the Hospital deemed service.
While tracing a patient in the CVICU, it was noted that the practitioner failed to document estimated blood loss in the operative report.

Chapter: Rights and Responsibilities of the Individual

Program: Hospital Accreditation

Standard: RI.01.03.01 ESC 60 days

Standard Text: The hospital honors the patient's right to give or withhold informed consent.

Primary Priority Focus Area: Information Management

Element(s) of Performance:

13. Informed consent is obtained in accordance with the hospital's policy and processes and, except in emergencies, prior to surgery. (See also RC.02.01.01, EP 4)

Scoring Category : C
Score : Partial Compliance

Observation(s):

EP 13
Observed in Tracer Activities at TriStar Centennial Medical Center (2300 Patterson Street, Nashville, TN) site.
During tracer activities multiple completed patient informed blood consent forms were found with one licensed personnel's signature. Hospital policy requires that when informed consent is obtained two licensed personnel must document witnessing of the informed consent.

Observed in Tracer Activities at TriStar Centennial Medical Center (2300 Patterson Street, Nashville, TN) site.
During tracer activities multiple completed patient informed consent forms for surgeries were found with one licensed personnel's signature. Hospital policy requires that when informed consent is obtained two licensed personnel must document witnessing of the informed consent.

Chapter: Environment of Care

Program: Critical Access Hospital Accreditation

Standard: EC.02.05.09 ESC 45 days

The Joint Commission
Findings

Standard Text: The critical access hospital inspects, tests, and maintains medical gas and vacuum systems.
Note: This standard does not require critical access hospitals to have the medical gas and vacuum systems discussed below. However, if a critical access hospital has these types of systems, then the following inspection, testing, and maintenance requirements apply.

Primary Priority Focus Area: Physical Environment

Element(s) of Performance:

1. In time frames defined by the critical access hospital, the critical access hospital inspects, tests, and maintains critical components of piped medical gas systems, including master signal panels, area alarms, automatic pressure switches, shutoff valves, flexible connectors, and outlets. These activities are documented. (See also EC.02.05.01, EP 3)

Scoring Category : A
Score : Insufficient Compliance

3. The critical access hospital makes main supply valves and area shutoff valves for piped medical gas and vacuum systems accessible and clearly identifies what the valves control.

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 1
§485.623(b)(1) - (C-0222) - (1) All essential mechanical, electrical, and patient-care equipment is maintained in safe operating condition;
This Standard is NOT MET as evidenced by:
Observed in Building Tour at TriStar Ashland City Medical Center (313 North Main Street, Ashland City, TN) site for the Critical Access Hospital – Acute deemed service.
During the building tour and staff discussion it was observed at the Ashland City hospital, that the hospital did not maintain the medical gas system as required by the NFPA. It was observed that the medical gas master alarm panel was not continuously monitored by staff as required. It was observed that the medical gas master alarm panel was installed in the corridor near the nurses station but not with in view of the nurses station. It was also observed and confirmed with staff that the nurses station is not occupied by staff at all times, and therefore the master alarm panel could not be continuously monitored as required.

EP 3
Observed in Building Tour at TriStar Ashland City Medical Center (313 North Main Street, Ashland City, TN) site.
During the building tour it was observed that the oxygen source shut off valve located at the bulk oxygen tank was not labeled.

Observed in Building Tour at TriStar Ashland City Medical Center (313 North Main Street, Ashland City, TN) site.
During the building tour it was observed that the medical gas zone shut off valve located in the endoscopy was not labeled to the areas it served,

The Joint Commission
Findings

Chapter: Life Safety

Program: Critical Access Hospital Accreditation

Standard: LS.02.01.10 ESC 45 days

Standard Text: Building and fire protection features are designed and maintained to minimize the effects of fire, smoke, and heat.

Primary Priority Focus Area: Physical Environment

Element(s) of Performance:

1. Buildings meet requirements for height and construction type in accordance with NFPA 101-2000: 18/19.1.6.2. 3

Scoring Category : A
Score : Insufficient Compliance

4. Openings in 2-hour fire-rated walls are fire rated for 1 1/2 hours. (See also LS.02.01.20, EP 3; LS.02.01.30, EP 1) (For full text and any exceptions, refer to NFPA 101-2000: 8.2.3.2.3.1) 4

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

The Joint Commission
Findings

EP 1
§485.623(d)(1) - (C-0231) - (1) Except as otherwise provided in this section, the CAH must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101 2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR Part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD and at the Office of the Federal Register, 800 North Capital Street NW, Suite 700, Washington, DC. Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes. Chapter 19.3.6.3.2, exception number 2 of the adopted edition of the Life Safety Code does not apply to a CAH.
This Standard is NOT MET as evidenced by:
Observed in Building Tour at TriStar Ashland City Medical Center (313 North Main Street, Ashland City, TN) site for the Critical Access Hospital – Acute deemed service.
During the building tour it was observed on the 1st floor that there was no fire proofing material located above the ceiling on the beams of the deck of the 2nd floor.

Observed in Building Tour at TriStar Ashland City Medical Center (313 North Main Street, Ashland City, TN) site for the Critical Access Hospital – Acute deemed service.
During the building tour it was observed on the 2nd floor that there was no fire proofing material located above the ceiling on the beams of the deck of the 3rd floor.

EP 4
§485.623(d)(1) - (C-0231) - (1) Except as otherwise provided in this section, the CAH must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101 2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR Part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD and at the Office of the Federal Register, 800 North Capital Street NW, Suite 700, Washington, DC. Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes. Chapter 19.3.6.3.2, exception number 2 of the adopted edition of the Life Safety Code does not apply to a CAH.
This Standard is NOT MET as evidenced by:
Observed in Building Tour at TriStar Ashland City Medical Center (313 North Main Street, Ashland City, TN) site for the Critical Access Hospital – Acute deemed service.
During the building tour it was observed that the rating of the fire door located at the 3rd floor north exit stair could not be verified due to the missing rating label.
During the building tour it was observed that the rating of the fire door located at the 2nd floor north exit stair could not be verified due to the missing rating label.

AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF DAVIDSON

JOHN WELLBORN, being first duly sworn, says that he/she is the lawful agent of the applicant named in this application, that this project will be completed in accordance with the application to the best of the agent's knowledge, that the agent has read the directions to this application, the Rules of the Health Services and Development Agency, and T.C.A. § 68-11-1601, *et seq.*, and that the responses to this application or any other questions deemed appropriate by the Health Services and Development Agency are true and complete to the best of the agent's knowledge.

SIGNATURE/TITLE

Sworn to and subscribed before me this 15th day of July (Month), 2014 (Year) a Notary Public in and for the County/State of Tennessee.

JAN M. DAVENPORT
STATE OF TENNESSEE NOTARY PUBLIC
DAVIDSON COUNTY
My Commission Expires November 5, 2014

NOTARY PUBLIC

My commission expires November (Month/Day), 2014 (Year).

SUPPLEMENTAL - #1
-Copy-

TRISTAR CENTENNIAL MEDICAL CENTER

CN1407-032

SUPPLEMENTAL #1
July 28, 2014
2:14 pm

DSG Development Support Group

July 25, 2014

Phillip M. Earhart, HSD Examiner
Tennessee Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243

RE: CON Application CN1407-032
TriStar Centennial Medical Center

Dear Mr. Earhart:

This letter responds to your recent request for additional information on this application. The items below are numbered to correspond to your questions. They are provided in triplicate, with affidavit.

1. **Section A, Applicant Profile, Item 4**
The applicant has provided documentation that verifies HCA Health Services of Tennessee, Inc. is registered as a corporation with the State of Tennessee. However, please provide documentation from the Tennessee Secretary of State that verifies HCA Health Services of Tennessee, Inc. has an assumed name of TriStar Centennial Medical Center.

Please see the attached materials following this page. HCA Health Services of Tennessee, Inc. has many assumed names, representing Middle Tennessee and Kentucky providers that it owns.

2. **Section A, Applicant Profile, Item 13**
The applicant's contractual relationships with AmeriGroup, United Community Healthcare Plan and TennCare Select are noted. However, new TennCare contracts will take effect January 1, 2015 with full statewide implementation for AmeriGroup, BlueCare Tennessee and United Healthcare. Please indicate if the applicant intends to contract with BlueCare Tennessee. If so, what stage of contract discussions is the applicant involved with BlueCare Tennessee?

TriStar has been working with BlueCare Tennessee in preparation of the changeover. The BlueCare contract covering hospital services to TennCare enrollees was signed on May 15, 2014.

4219 Hillsboro Road, Suite 203
Nashville, TN 37215
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SUPPLEMENTAL #1
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2:14 pm

3. Section B, Project Description, Item II.A.

a. The applicant states on page 7 the center for Joint Replacement Program's cases will significantly increase in the near future due to the increased surgical staff in late 2014. Please clarify if there will be a contract with the Southern Joint Replacement Institute to provide surgical staff. If so, what is the length of the agreement?

Yes. The parties have executed an Asset Purchase Agreement and a Physician Services Agreement. Each agreement is subject to a confidentiality agreement between the parties, and the terms thereof cannot be disclosed. The initial term of the Physician Services Agreement is 5 years.

b. Please clarify the reason the oversize elevator to be added that will extend from the motor lobby up through the eight floor does not go to the 9th floor where a helipad will be relocated.

The proposed oversize elevator bank on the corner of the Tower will be for patients and staff using the cardiac floors (2-3) and orthopedic floors (7-8). It has no need to go above the 8th floor because the 9th floor is not part of the Joint Replacement Center, at least initially. However, the elevator can be extended vertically if needed in future years. The helipad above the 9th floor will utilize another set of elevators; see question 3d below.

c. Please compare the existing rehabilitation space on the 6th floor with the new proposed space on the 8th floor.

In recent years, the sixth floor space has been used almost entirely for joint replacement patients' educational sessions and evaluations. It is a room of c. 850 SF, set up with chairs, tables, a lectern, audiovisual and computer equipment for sessions held throughout the week. It is not practical to remove or store this material in order to use the area as a gym, and the only rehabilitation equipment there now are mats and wall pulleys that are no longer used. In the new seventh floor space, the room will be similar in size but will have a stair system, two "high/low" mats for stretching, three recumbent stair machines, and a partial "car" for retraining patients in the use of an automobile. The room will be dedicated to rehabilitation, and will not be furnished for dual use as a classroom.

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d. Please describe existing helipad and compare it to the proposed new helipad. In your response please discuss the space requirements and any improved access for emergency care.

The existing helipad is a square, approximately fifty feet on a side, with a landing surface of painted concrete, surrounded by a wire safety net. It is connected by a short ramp to the rooftop penthouse, which houses an elevator that provides access to the Emergency Room and to other floors of Centennial. It provides excellent access for arriving patients and needs no improvements; it is being replaced only because the new ninth floor will displace it from the roof of the eighth floor.

The new helipad will be identical in design. The elevator bank currently serving the eighth floor penthouse will be extended up into the new ninth floor rooftop penthouse, whose entrance will be connected by a ramp to the new helipad.

e. Please complete the square footage and costs per square footage chart located in Attachment B.II.A.

The cost per square foot chart is attached following this page.

f. Table Three on page 17 is noted. However, please breakout the construction cost for new construction and renovation, as well as the cost PSF for each.

Revised pages 12R, 17R, and 63R, with those more specific cost factors, are attached following this page.

SUPPLEMENTAL #1
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2:14 pm

4. Section B, Project Description, Item II.C.

a. Table Ten-B on page 22 is noted. However, the proposed 24 rooms for the emergency department appears to fall short of the recommended minimum of 25 rooms for annual visits over 40,000 by the American College of Emergency Physicians. Please clarify.

The ACEP Guidelines are only a professional society's guidelines; they are not State licensure or AIA design standards. HCA follows its own Emergency Department programming standards of approximately 1,800-2,000 visits per treatment room, to which this project conforms. The proposed treatment room complement is within one room of the low end of the range that ACEP recommends. The proposed complement is appropriate for the visits projected in the application.

(Reviewer: The application on page described HCA's design standards as 1,800-2,200 SF per treatment room; that was a typographical error--the standard is 1,800-2,000 SF per room.)

b. If this proposed project is approved, at what annual emergency room volume will additional rooms in the emergency department be needed?

As future annual visits approach 2,000 per station, the ED can be expanded incrementally into vacant adjoining space remaining from a former cardiac cath laboratory. So as visits approach 48,000 annually, the need for an expansion will be evaluated.

c. Exhibit Ten-D on page 28 is noted. However, please provide the table minus observation beds.

A revised page 28R is attached after this page. It provides an additional Table showing only discharge days, and not including bed days used by observation patients. Centennial has no observation beds; so the bed complements in the original table have not been changed.

SUPPLEMENTAL #1
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5. Need, Item 1. (Service Specific Criteria-Acute Care Bed Services, #1)

a. Please indicate the 2012 licensed occupancy of inpatient medical surgical beds for each of the HCA hospitals in the applicant's service area.

Attached following this page is a table with CY2013 medical-surgical occupancy data for the area's HCA hospitals. It is more current than CY2012.

b. On page 33 of the application, it is noted there is a surplus of 1,455 acute care hospital beds in the proposed service area. With this in mind, has the applicant considered de-licensing 29 inpatient med surgical beds at another HCA owned hospital in the service area so that 29 additional medical surgical beds are not added to a service area that already has a surplus of medical surgical beds? Please discuss.

The only remaining beds which HCA will consider transferring within the area are at Skyline Medical Center's Madison campus. As stated to the HSDA Board in its recent review of the Summit Medical Center application for eight additional licensed beds (approved), all of those Madison beds are being held for transfer to Skyline's own main campus, in an expansion that is likely to be requested within the year.

For more than 10 years, TriStar has implemented bed transfers among its area hospitals, from low-utilization hospitals to high-utilization hospitals, to meet its patients' needs without increasing the supply of licensed beds in the service area. There are no more such beds to offer. The licensed medical-surgical beds at its hospitals are being well-utilized in peak periods by both admitted patients and observation patients, or will be so utilized as demand continues to increase under the Affordable Care Act's expanded coverage of area residents.

It should be noted that the 29 additional beds proposed here are for a "specialty unit" in a "tertiary care regional referral hospital"--which the Guidelines identify as an approvable exception to the State bed need formula. Offsetting bed delicensures should not be required where such an exception applies. That would be contrary to the intent of the Guidelines.

Centennial Medical Center CON Application CN1407-032
Response to First Supplemental Request--Question 5
HCA Service Area Hospitals
CY 2013 Medical-Surgical Beds & Occupancy

TriStar Hospitals in Service Area	Licensed M/S Beds*	Discharges	Discharge Days	Occupancy %	Observation Days	Occupancy % w/ Obs
Centennial Medical Center	281	14,935	72,415	70.6%	15,941	86.1%
Centennial Med Center Ashland City	12	201	1,432	32.7%	99	35.0%
Skyline Medical Center	138	6,564	33,398	66.3%	8,788	83.8%
Southern Hills Medical Center	53	2,603	12,068	62.4%	4,792	87.2%
Summit Medical Center	110	5,987	24,645	61.4%	10,014	86.3%
Hendersonville Medical Center	73	3,558	14,790	55.5%	1,890	62.6%
StoneCrest Medical Center	67	2,973	10,252	41.9%	7,413	72.2%
Total	734	33,848	158,748	59.3%	48,937	77.5%

Source: Hospital Management.
**Excludes OB/GYN data*

6. Need, Item 1. (Service Specific Criteria-Construction, Renovation, Expansion, and replacement of Health Care Institutions, #3)
The applicant mentions the imminent arrival on campus of a large regionally known joint replacement surgery group. Where was this group previously located and for how long?

The Southern Joint Replacement Institute's practice office has been consolidated at Saint Thomas West Hospital since 2007.

In past years SJRI has also had offices at Saint Thomas Midtown (Baptist) and at Vanderbilt Medical Center.

7. Section C, Need, Item 2.
The long-term plan for Centennial's Joint Replacement program is noted. However, what are the long-range development plans for acute care beds and the emergency department?

Centennial plans to continue to be responsive to community needs, providing beds and services requested by medical staff and patients when need is strongly demonstrated. The Tower can expand for several more floors and Centennial will soon explore proposing additional shelled floors if demand for beds meets or exceeds current expectations. The Emergency Department may well need additional treatment areas within five years; so currently vacant space adjoining the ED is being held to ensure that such expansion will be possible and cost-effective.

8. Section C, Need, Item 4.B.
Please verify if there are any federal designated medically underserved areas in the applicant's service area.

Attached at the end of this supplemental response letter are materials identifying MUA's in the primary service area. All eight counties appear to have had one or more areas designated as medically underserved areas.

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9. Section C, Need, Item 5

The applicant makes note on the bottom of page 47 that Joint Annual Report data is incomplete in regards to total bed occupancy. Does the current Joint Annual Report capture observation bed days? Please clarify.

The current JAR form does not capture observation patient data in usable form, i.e., with the detail needed to present annual average occupancy of beds by assignment (i.e., medical-surgical, obstetrics, psychiatric, etc. beds).

On page 17 it captures the number of annual outpatients classified as "23-hour" observation. It does not capture cumulative total annual bed days or bed assignments for those patients as a group. Nor does it appear to capture "observation" stays longer than 23 hours, which are now commonplace.

On page 23 it captures data on beds used for 23-hour observation *patients*; but the JAR does not capture cumulative observation days per year for those patients or longer-stay observation patients. Also, although some types of admissions/discharges and bed days are captured on other pages of the JAR (rehabilitation, critical/intensive care, behavioral), it appears that OB postpartum days are not recorded; so it is not possible to accurately reach even "admitted" medical-surgical days by themselves, through subtracting other types of bed days from the total bed days captured on page 25 of the JAR.

10. Section C, Need, Item 6.

a. The applicant refers to emergency department service levels and CPT codes in Table Sixteen-B and Table Eighteen-C. Please provide a brief overview of each CPT code from 99281 to 99285.

99281 -- Emergency Department visit for evaluation and management of a patient which requires these 3 key components:

- A problem Focused history
- A problem focused examination
- Straightforward medical decision making.

Usually the presenting problems are self limited or minor.

99282 -- Emergency Department Visit for the evaluation and management of a patient, which requires these 3 key components:
- An Expanded Problem Focused History
- An expanded problem focused examination
- Medical Decision Making of low complexity

Usually presenting problems are low to moderate severity.

99283 -- Emergency Department visit for the evaluation and management of a patient, which requires these 3 key components:
- An Expanded Problem Focused History
- An expanded problem focused examination
- Medical Decision Making of moderate complexity

Usually presenting problems are of moderate severity.

99284 -- Emergency Department visit for the evaluation and management of a patient, which requires these 3 key components:
- A detailed History
- A detailed examination
- Medical Decision Making of moderate complexity

Usually the problems are of high severity and require urgent evaluation by the physicians or other healthcare professionals but do not pose immediate significant threat to life or psychological function.

99285 --Emergency Department visit for the evaluation and management of a patient, which requires these 3 key components within the constraints imposed by the urgency of the patients clinical condition and/or mental status:
- A comprehensive History
- A comprehensive examination
- Medical Decision Making of high complexity

Usually the presenting problems are of high severity and pose immediate significant threat to life or psychological function.

b. Please clarify why there are more complex Level III, IV and V emergency room visits in relation to less complex cases of level I and II.

TriStar Centennial Medical Center is a tertiary referral center. Its Emergency Department (ED) receives a large number of transfers of seriously ill or injured patients, coming from other area hospitals or from emergency response teams. In addition, Centennial has a Kids Express outpatient center on campus to better serve pediatric Level I and II patients; and there is an HCA CareSpot near the campus on West End Avenue, for serving urgent care adults. Those are the reasons why the visit acuity mix at the main ED reflects relatively higher acuity patients, when compared to many smaller hospitals' ED's.

c. Where are emergency room trauma patients referred?

The designated trauma centers in Davidson County are Vanderbilt Medical Center and TriStar Skyline Medical Center; these normally receive trauma patients from the emergency response system.

d. Are all observation days taking place in licensed beds?

Yes. Few hospitals have "observation units" anymore.

e. Exhibit Sixteen-C on page 51 is noted. However, for comparative purposes please provide the same table without observation bed data.

Please see the following attached page, where Table Sixteen-C is expanded into Sixteen-C(1) and (2) to show side by side comparisons. This expanded Table is identical to supplementalTables Ten-D (1) and (2) submitted as revised page 28R, earlier in this supplemental response letter.

Table Sixteen-C (1): Historic and Projected Medical-Surgical Bed Utilization TriStar Centennial Medical Center CY2011-CY2017 (SUPPLEMENTAL TABLE TO PAGE 51)					
Year	**Med-Surg Beds**	**Med-Surg Bed Annual Capacity**	**Bed Days, Including Obs. Days**	**Avg. Daily Census on Total Days**	**Total Average Occupancy**
Historic					
CY2011	258	94,170	69,558	190.6	73.9%
CY2012	281	102,846	81,423	222.5	79.2%
CY2013	281	102,565	84,959	232.8	82.8%
Projected					
CY2014	281	102,565	89,553	245.4	87.3%
CY2015	281	102,565	98,669	258.0	96.2%
Yr 1 CY2016	310	113,460	103,774	284.3	91.7%
Yr 2 CY2017	310	113,150	109,149	299.0	96.5%

Table Sixteen-C(2): Historic and Projected Medical-Surgical Bed Utilization TriStar Centennial Medical Center CY2011-CY2017 (SUPPLEMENTAL TABLE TO PAGE 51)					
Year	**Med-Surg Beds**	**Med-Surg Bed Annual Capacity**	**Disch. Days Excluding Obs. Days**	**Avg. Daily Census on Disch. Days**	**Total Average Occupancy**
Historic					
CY2011	258	94,170	63,894	175.1	67.8%
CY2012	281	102,846	67,887	185.5	66.0%
CY2013	281	102,565	72,415	198.4	70.6%
Projected					
CY2014	281	102,565	75,226	206.1	73.3%
CY2015	281	102,565	83,849	229.7	81.8%
Yr 1 CY2016	310	113,460	88,844	242.3	78.2%
Yr 2 CY2017	310	113,150	93,291	255.6	82.4%

Source: Table Sixteen-C. CY2012 and CY2016 are 366-day leap years.

f. Please provide the following information for Centennial Medical Center for the most recent year available.

CY2013	No. of Rooms	Cases	Cases/ Room	Minutes Used	Average Turnaround Time	Schedulable minutes*	% of Schedulable Time Used
Operating Rooms							
Endoscopy Procedure Rooms							
Cystoscopy Rooms							
Other Procedure Rooms							
Total Surgical Suite							

* defined as the summation of the minutes by each room available for scheduled cases Example: 7:30 AM to 4:30 PM, 5 days per week, 50 weeks/ year, equates to 9 hrs/day X 60 min/hr = 540 minutes/day X 5 days/week = 2,700 minutes / week X 50 weeks/year=135,000 schedulable minutes/room X the number of rooms=surgical suite schedulable capacity

This table is attached on the following page.

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Centennial Medical Center Surgical Rooms--Capacity and Utilization							
CY2013	Number of Rooms	Cases	Cases/Room	Minutes Used	Average Turnaround Time in Minutes	Schedulable Minutes	Percent of Schedulable Time Used
Total Operating Rooms	**43**	**20,792**	**484**	**2,478,207**	**665,344**	**5,160,000**	**60.92%**
Endoscopy Procedure Rooms	16	9,790	612	328,180	97,900	1,920,000	22.19%
Cystoscopy Rooms	-	-	-	-	-	-	-
Other Procedure Rooms	5	535	107	24,440	8,025	600,000	5.41%
Total Procedural Rooms	**21**	**10,325**	**492**	**352,620**	**105,925**	**2,520,000**	**18.20%**
All Surgical Rooms, Sterile and Non-Sterile	**64**	**31,117**	**486**	**2,830,827**	**771,269**	**7,680,000**	**46.90%**

*32 minutes average TAT for TCMC ORs; HCA goal is 30 minutes

*Endo TAT average for TCMC is 10 minutes

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11. Section C. Economic Feasibility Item 1 (Project Cost Chart) and Item 3

a. Please clarify financing costs of $3,801,318 listed in C.4 in the Project Costs Chart as Escalation Factor, 2%/2 yrs.

This amount should have been included in the contingency line; attached after this page is a revised Project Cost Chart. This amendment does not change the project cost.

b. The Architect's letter in the attachment is noted. However, please document the proposed project will conform to the 2010 AIA Guidelines for Design and Construction of Hospital and Health Care Facilities .

The architect has responded that "*we have stated in the letter that the...design of the project will meet current codes that will be applicable at the time of final design....At this current time the 2010 Guidelines for the Design and Construction of Health Care Facilities are applicable, however it is possible that by the time this project can move forth, the 2014 Guidelines may be applicable. So for the letter, we simply stated that the Guidelines will be met.*"

Based on this the applicant requests that a revised letter not be required, since the specific document was referenced generically and the commitment to meet applicable versions was very clear. This seems to be a better commitment than naming the current year's edition.

12. Section C, Economic Feasibility, Item 4 (Historical Data Chart and Projected Data Chart)

Please clarify why management fees (in relation to gross operating revenue) are lower on the Projected Data Charts for the Joint Replacement Center of Excellence (.81%-.90%) and the Main Emergency Department (.19%-.21%), than the management fees (1.3%-1.6%) on the Historical Data Chart for 2011-2013 for Centennial Medical Center.

The applicant is submitting revised Projected Data Charts for both services, allocating larger management fees using the whole hospital's CY2013 experience as reflected in the last column of the Historic Data Chart (management fees equal c. 1.43% of gross revenue).

Although this is an insignificant change, it does change the last entries in the two tables on page 73 of the application. Revised page 73R is attached after the two revised Projected Data Charts.

13. Section C, Economic Feasibility, Item 9

a. Please discuss how the medically indigent will be served by this proposed project.

The project's total charity care deduction ($4,554,175) is approximately 1% of the project's total gross charges ($463,461,609).

b. Please briefly discuss how the Affordable Care Act will impact unreimbursed patient care and profitability.

Centennial anticipates that most uninsured patients that have been treated in the past (under substantial discount policies for the uninsured) will now be able to purchase insurance through an exchange. To the extent this happens, revenues from an enlarged pool of commercially insured patients will increase.

However, it is difficult to project increased profitability from this alone, due to the likelihood of continuing reimbursement restrictions imposed by Medicare and followed by some insurers.

14. Section C, Orderly Development, Item 1.
Please list the managed care organizations, alliances, and/or networks with which the applicant currently has or plans to have contractual agreements for health services.

TriStar Centennial Medical Center's contractual agreements with payors are listed on a sheet following this page. As stated on page 4 of the application, these include all three TennCare MCO's in this area. The response to question 2 of this letter points out that the hospital contract for TennCare services to BlueCare Tennessee members was signed in May. TriStar also has an agreement with an Emergency Department staffing company, to provide physician coverage of the Centennial Emergency Departent. There are no alliances or networks with which the applicant has, or plans to have, contractual agreements.

15. Section C, Orderly Development, Item 2.

a. The applicant mentions the pending 1,500 case relocation of Southern Joint Replacement Initiative patients. Please discuss the status of this pending relocation.

Their relocation to Centennial is certain. All four SJRI physicians are already members of the Centennial Medical Staff and the practice has signed a Professional Services Agreement. SJRI will move its practice office to the Physicians Park Medical Office Building on the CMC campus. The office lease has been signed; renovation is underway; and the group is projected to move into that office space in November 2014.

b. Please clarify if the pending 1,500 case relocation of Southern Joint Replacement Initiative patients is contingent upon the approval of this application.

No, it is not contingent on approval of this application. This application proposes a beneficial consolidation of patient intake, preparation, surgery, recovery, and rehabilitation of SJRI's and others' patients in a new Center of Excellence for Joint Replacement. If it is not approved, the relocation of SJRI and its cases will still occur as scheduled. However, until this project can be implemented, the additional SJRI patient days and cases will put an undue strain on daily operations of both beds and the Surgery Department.

SUPPLEMENTAL #1

TriStar Centennial MEDICAL CENTER

2:14 pm

2014 HEALTH PLANS AND INSURANCE CARRIERS

- AARP UHC Medicare Complete POS, PPO, Secure Horizons HMO
- Aetna HMO, PPO, Federal, Open Choice, PPO, Elect Choice EPO, HMO Psych, PPO Psych
- Alive Hospice Nashville
- Amerigroup Advantage Medicare, Amerivantage Mcare Advantage BMT
- Beech Street
- BlisCare
- Blue Cross Network P, FEP
- BC of TN Blue Advantage Mcare PPO, BC of TN Medicare Advantage,
- BC Health Exchange Network P
- BC Dept of Corrections
- BCBS Tncare Select
- Bluegrass Family Health SingleSource,
- Cigna Behavioral Health
- Cigna Flexcare, HCA, HMO, Local Plus, TN Select
- Cigna Health Exchange
- Community Health Alliance [CHA], Community Health Exchange
- ComPsych
- Correct Care Solutions
- Cover Kids, Cover Tn [Behavioral ONLY]
- First Health Network/CCN/Coventry
- GEHA PPO USA / GEHA PCIP
- Great West HMO, PPO, POS [formerly One Health Plan]
- Healthspring Plus, HMO
- Healthspring Medicare Plus, Healthspring Medicare PPO, Medicare Plus BMT, Medicare Psych, Healthspring Tricare Mcare
- Humana ChoiceCare Narrow Network, POS, BMT
- Humana Health Exchange
- Humana Gold Plus HMO, Humana Choice Mcare PPO, Gold Choice PFFS
- John Deere Health Plan
- Kindred Hospital
- Humana Health Exchange
- Lifesynch Mcare Advantage
- Mail Handlers
- Magellan Behavior Health [all networks]
- Multiplan, Inc / PHCS, *~please note patient may have limited benefits/will owe what ins does not pay, confirm w/ins~*
- NovaNet, NovaNet Work Comp
- Odyssey Healthcare, Inc [Hospice]
- Optum Health Commercial BMT, PPO BMT, Optum Health Mcare Adv BMT
- PCIP [Pre Existing Condition Ins]
- PHCS, PHCS Limited Benefit Plan
- Plumbers Pipe Local 572
- Principle Edge Network
- PsychCare Medicare Advantage
- Secure Horizons Medicare Complete, Mcare PFFS
- Signature Health
- Southern Benefits Admin HMO
- Sterling Life Insurance PFFS
- Tennessee Worker's Compensation
- Tn Donor Services
- Tncare Select, VSHP
- Tncare UHC Community Plan
- Today's Option Medicare PFFS [Pyramid Life]
- Tricare Region South [Humana], Region North [Healthnet Federal Service], Tricare Other, Tricare – Champus
- UHC Group Mcare Advantage, Dual Complete Medicare, United Behavioral Hlth Mcare
- UHC of the River Valley HMO
- UHC HCA, HMO, POS, PPO
  - Other PPO's w/ their own I-plans – Fiserve Health, Golden Rule, Pacificare Health Systems, American Medical Securities, Oxford health Plans, Neighborhood Health, Definity Health
  - Unitedhealth Basics [has limited benefits], Indemnity-non contracted
- United Behavioral Health
- Value Options
- Veterans Administration

** For any insurance plan not listed above, please contact:

David Summers, CFO at (615) 342-1005
David.Summers@hcahealthcare.com

Updated 03/2014

c. What is the current hospital that houses SJRI? What is the percentage of the pending 1,500 case relocation of SJRI patients in relation of the overall surgical volume at the current hospital?

The cases projected to come to Centennial Medical Center, according to SJRI, are presently being performed at Saint Thomas West Hospital, where the SJRI main practice office is located. The 2013 Joint Annual Reports indicate that the following total surgeries were performed at Saint Thomas's three Nashville facilities.

Projected Case Relocations as Percent of Total Cases			
Saint Thomas Facilities	Cases Moving to CMC	Total Cases, 2013 JAR	Percent of Total Cases
ST West	1,500	11,779	12.7%
ST Midtown	0	15,555	
ST Hosp. for Spinal Surgery	0	3,319	
Total Saint Thomas System	**1,500**	**30,653**	**4.9%**

Source: Reported encounters, all surgeries, p, 12 of 2013 Joint Annual Reports

d. Also, what percentages of the 1,500 cases are served by Blue Cross and Blue Shield insurance? Will these cases be considered out of network?

The SJRI group's BCBS payer mix is approximately 26% at this time, of which less than half is under the Blue Cross S Plan, with which Centennial is not contracted. The application assumes that SJRI's S Plan enrollees will continue to be served at facilities other than Centennial.

Please take note that the estimated relocation of 1,500 cases *excluded* SJRI's S Plan cases and others; the 1,500 expected cases represents approximately 75% total current SJRI cases at all locations.

16. Proof of Publication

Attach a full page of the newspaper in which the notice of intent appeared with the mast and dateline intact or submit a publication affidavit from the newspaper as proof of the publication of the letter of intent.

An affidavit of publication and a full page of the newspaper are attached following this page.

17. Affidavit

A signed affidavit must be submitted with each filing of an application and supplemental information. A signed affidavit was not included with this application. Please submit a completed affidavit for the original application and one for the supplemental information.

Attached following this page.

Additional Items from the Applicant

1. Attached is a graph of the applicant's medical-surgical bed utilization in recent months. It illustrates how census peaks exceed high occupancy on existing beds, and how those peaks would relate to a proposed 29-bed increase. This was mentioned in the original application on page 51 but was omitted inadvertently in the submission.

2. Note concerning originally submitted Table Sixteen-F (O.R. utilization)--it did not include turnaround minutes. The surgical room utilization chart submitted for your question 10-f above does include turnaround minutes. The applicant will amend Table Sixteen-F to include minutes if required.

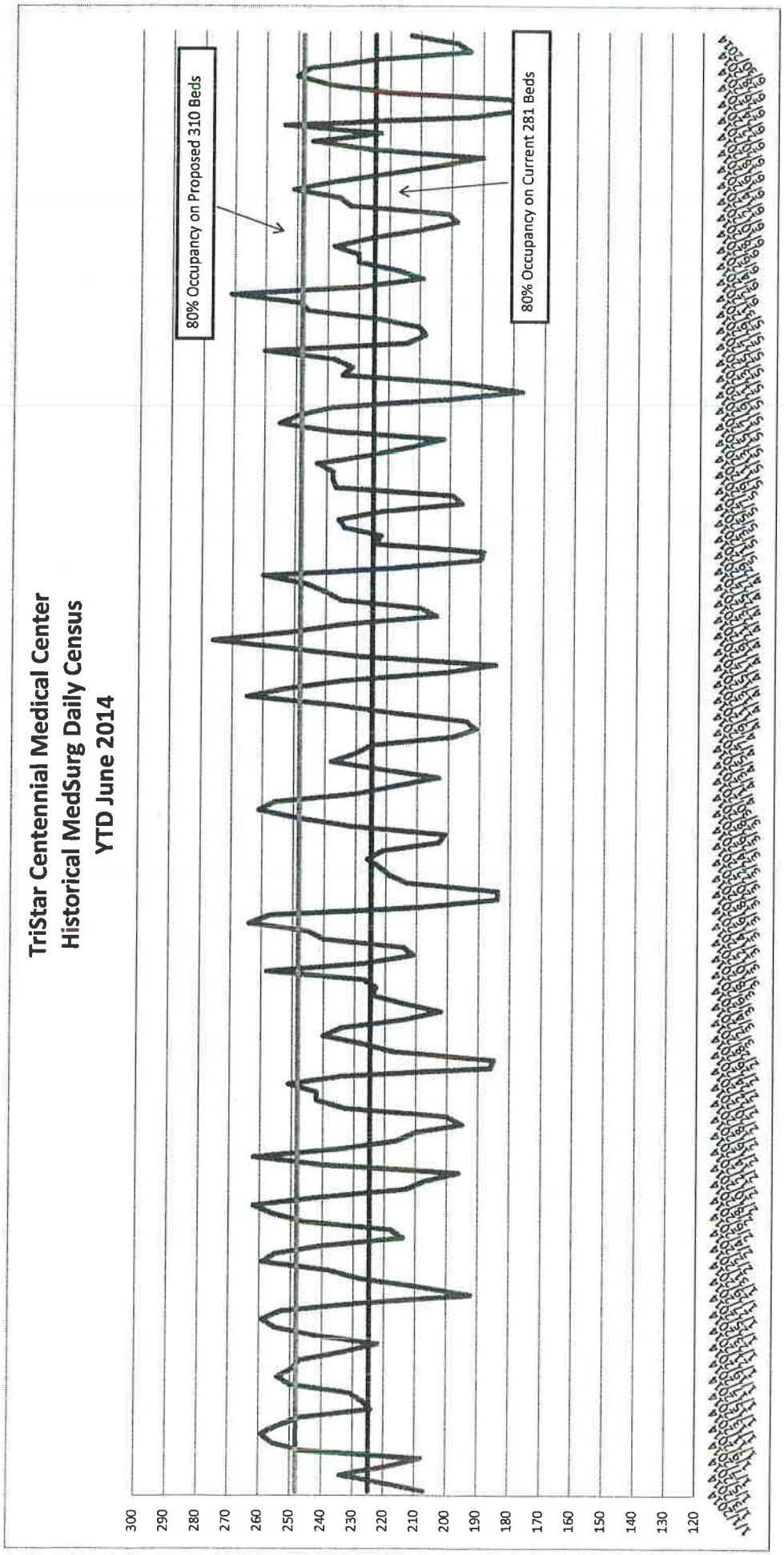
Thank you for your assistance. We hope this provides the information needed to accept the application into the next review cycle. If more is needed please FAX or telephone me so that we can respond in time to be deemed complete.

Respectfully,

John Wellborn

John Wellborn
Consultant

SUPPLEMENTAL #1
July 28, 2014
2:14 pm



SUPPLEMENTAL #1
July 28, 2014
2:14 pm

AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF DAVIDSON

JOHN WELLBORN, being first duly sworn, says that he/she is the lawful agent of the applicant named in this application, that this project will be completed in accordance with the application to the best of the agent's knowledge, that the agent has read the directions to this application, the Rules of the Health Services and Development Agency, and T.C.A. § 68-11-1601, *et seq.*, and that the responses to this application or any other questions deemed appropriate by the Health Services and Development Agency are true and complete to the best of the agent's knowledge.

John T Wellborn
SIGNATURE/TITLE

Sworn to and subscribed before me this 25th day of July (Month), 2014 (Year) a Notary Public in and for the County/State of Tennessee.

JAN M. DANFORTH
STATE OF TENNESSEE
NOTARY PUBLIC
DAVIDSON COUNTY
My Commission Expires July 2, 2018

NOTARY PUBLIC

My commission expires July 2, (Month/Day), 2018 (Year).

TRAUGER & TUKE
ATTORNEYS AT LAW
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222 FOURTH AVENUE NORTH
NASHVILLE, TENNESSEE 37219-2117
TELEPHONE (615) 256-8585
TELECOPIER (615) 256-7444

October 7, 2014

Ms. Melanie M. Hill
Executive Director
Health Services & Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243

RE: TriStar Centennial Medical Center
CN1407-032

Dear Melanie:

We are counsel for Baptist Women's Health Center, LLC d/b/a Saint Thomas Hospital for Specialty Surgery ("Hospital"). The Hospital opposes the referenced application for a certificate of need on the grounds that the application fails to meet the statutory requirements for a certificate of need.

Representatives of the Hospital will be present at the October 22, 2014 hearing to express their opposition.

Very truly yours,

Byron R. Trauger

BRT:kmn

cc: Jerry W. Taylor, Esquire, Stites & Harbison

KRAMER RAYSON LLP

ATTORNEYS AT LAW

POST OFFICE BOX 629
KNOXVILLE, TENNESSEE 37901-0629

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R.R. KRAMER (1888-1966)

October 3, 2014

Via Federal Express

Melanie Hill, Executive Director
Health Services and Development Agency
Andrew Jackson Building
502 Deaderick Street, 9th Floor
Nashville, TN 37243

Re: TriStar Centennial Medical Center
CN1407-032

Dear Ms. Hill:

This letter of opposition regarding the above referenced application is being submitted on behalf of our clients, Saint Thomas West Hospital and Saint Thomas Midtown Hospital. We respectfully submit that the application does not meet the three statutory criteria required for approval. Representatives of Saint Thomas will be present to speak in opposition to the application at the Agency's meeting on October 22, 2014. We also request 15 minutes of additional time to present our opposition.

Sincerely,

Warren L. Gooch

WLG:dt
cc: John Wellborn, Development Support Group

Bernie Sherry, President and CEO
Saint Thomas West Hospital and Saint Thomas Midtown Hospital

Blake Estes, Executive Director, Strategy and Planning
Saint Thomas Health

LETTER OF INTENT -- HEALTH SERVICES & DEVELOPMENT AGENCY

The Publication of Intent is to be published in the Nashville Tennessean, which is a newspaper of general circulation in Davidson County, Tennessee, on or before July 10, 2014, for one day.

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. Sections 68-11-1601 et seq., and the Rules of the Health Services and Development Agency, that TriStar Centennial Medical Center, a hospital, owned and managed by HCA Health Services of Tennessee, Inc., a corporation, intends to file an application for a Certificate of Need to renovate its main Emergency Department; to develop a Joint Replacement Center of Excellence that will include ten (10) additional operating rooms; and to increase the hospital's licensed bed complement. These will take place at its main hospital facility at 2300 Patterson Street, Nashville, TN 37203, at a capital cost estimated at $94,000,000.

Centennial is licensed as a 657-bed acute care hospital by the Board for Licensing Health Care Facilities. The project will increase Centennial's total licensed bed complement to 686 beds, an increase of 29 beds. The project includes a CT scanner for the Emergency Department, but does not include major medical equipment, or initiate or discontinue any health service.

The anticipated date of filing the application is on or before July 15, 2014. The contact person for the project is John Wellborn, who may be reached at Development Support Group, 4219 Hillsboro Road, Suite 210, Nashville, TN 37215; (615) 665-2022.

John R Wellborn 7-8-14 jwdsg@comcast.net

(Signature) (Date) (E-mail Address)

CERTIFICATE OF NEED
REVIEWED BY THE DEPARTMENT OF HEALTH
DIVISION OF POLICY, PLANNING AND ASSESSMENT
615-741-1954

DATE: September 30, 2014

APPLICANT: TriStar Centennial Medical Center
2300 Patterson Street
Nashville, Tennessee 37203

CN1407-032

CONTACT PERSON: John L. Wellborn, Consultant
Development Support Group
4219 Hillsboro Road, Suite 210
Nashville, Tennessee 37215

COST: $96,192,007

In accordance with Section 68-11-1608(a) of the Tennessee Health Services and Planning Act of 2002, the Tennessee Department of Health, Division of Policy, Planning, and Assessment, reviewed this certificate of need application for financial impact, TennCare participation, compliance with *Tennessee's State Health Plan*, and verified certain data. Additional clarification or comment relative to the application is provided, as applicable, under the heading "Note to Agency Members."

SUMMARY:
The applicant, TriStar Centennial Medical Center (TCMC), located in Nashville (Davidson County), Tennessee, seeks Certificate of Need (CON) approval to develop a Joint Replacement Center of Excellence, to offer a centralized continuum of care that includes co-located patient intake and staging, 10 specialized operating rooms, recovery, and a unit of 29 additional licensed beds for post-surgical and rehabilitation of joint replacement patients. This project will require renovation and expansion of the Tower's seventh and eight floors, and construction of a new ninth floor to house 36 medical/surgical beds being displaced from the eighth floor. The hospital's acute care complement will increase from 657 to 686 licensed beds.

The hospital's Tower Emergency Room will be renovated to become more efficient, reducing treatment stations from 28 to 24. And replacing and adding equipment that includes a dedicated CT scanner for emergency patients.

The project involves 84,123 square feet of new construction and 89,318 square feet of renovated space for a total of 173,441 square feet. The square foot cost for new construction is $358.82 and the renovated cost per square foot is $242. The total cost per square foot combined is $298.66. HSDA approved construction cost per square foot'

TriStar Centennial Medical Center is wholly owned by HCA Health Services of Tennessee, Inc., whose ultimate parent company is HCA, Inc. Attachment A.4 contains an organizational chart and information of the Tennessee facilities owned by this facility's parent company.

GENERAL CRITERIA FOR CERTIFICATE OF NEED

The applicant responded to all of the general criteria for Certificate of Need as set forth in the document *Tennessee's State Health Plan.*

NEED:
The applicant's projected service area population projections are illustrated in the table below.

Service Area Population Projections for 2014 and 2018

County	2014 Population	2018 Population	% Increase/ (Decrease)
Cheatham	39,853	40,765	2.3%
Davidson	656,385	682,330	4.0%
Montgomery	187,649	200,561	6.9%
Robertson	70,391	74,371	5.7%
Rutherford	293,582	329,446	12.2%
Sumner	172,262	183,406	6.5%
Williamson	202,923	223,333	10.1%
Wilson	124,073	133,357	7.5%
Total	**1,747,118**	**1,867,569**	**6.9%**

Source: *Tennessee Population Projections 2000-2020, June 2013 Revision, Tennessee Department of Health, Division of Policy, Planning, and Assessment-Office of Health Statistics*

2012 Service Area Acute Care Hospital Licensed and Staffed Bed Occupancy

Facility	Licensed Beds	Staffed Beds	Licensed Occupancy	Staffed Occupancy
Centennial Med Ctr. Ashland City	12	12	35.4	35.4
Saint Thomas West Hospital	541	404	50.7	68.0
Skyline Medical Center	213	209	66.9	68.2
The Center for Spinal Surgery	23	23	18.1	18.1
Southern Hills Medical Center	132	81	37.0	60.4
Metro Nashville General Hospital	150	116	31.8	41.1
Saint Thomas Hospital Midtown	683	453	45.0	67.8
Vanderbilt University Medical Ctr.	985	966	76.5	78.0
Centennial Medical Center	657	630	61.7	64.3
Summit Medical Center	188	137	62.3	85.4
Sumner Regional Medical Center	155	117	49.4	65.4
Hendersonville Medical Center	110	96	50.9	58.3
University Medical Center	170	170	55.5	55.5
Gateway Medical Center	270	220	42.1	51.7
NorthCrest Medical Center	109	66	39.6	65.4
St. Thomas Rutherford	286	268	62.5	66.7
StoneCrest Medical Center	101	101	42.0	42.0
Williamson Medical Center	185	185	46.7	46.7

Source: *Joint Annual Report of Hospitals 2012,* Division of Health Statistics, Tennessee Department of Health

According to the most recent final Joint Annual Report of Hospitals, 2012, there are 5,265 licensed hospital beds in the service area. No service area facility had a licensed occupancy of over 76.5%.

The Division of Policy, Planning, and Assessment calculated the service area acute care bed need to be a surplus of 1,455 beds.

The applicant justifies the need for this project by present the following arguments:

- In CY 2015, additions to TriStar's Centennial's surgical will more than double the caseloads of its existing Joint Replacement program. The medical staff and hospital have determined to locate future Joint Replacement surgeries in a physically and operationally dedicated Center of Excellence that contains every step of the continuum of care for these patients. The objectives of this consolidation are to continuously improve outcomes and efficiency for this group of patient, achieving goals of quality and cost effectiveness through collaborative management by the hospital and its orthopedic surgeons. One on the goals of the projects is to remove these patients from the areas of the hospitals where infectious

patients are served and make it easier for patients with joint pain to reach services within the hospital with minimal effort.

- The applicant justifies the addition of 29 licensed orthopedic medical/surgical beds due to the current medical/surgical bed capacity at Centennial being at a very high occupancy throughout the year (87%) and the additional 1,500 joint replacement cases projected to arrive with medical staff expansion in 2015. Southern Joint Replacement Institute (SJRI), Nashville physician group of four orthopedists specializing in joint replacement cases is relocating their offices and cases to Centennial's campus and intend to recruit a fifth physician by January 2015. The new specialized operating rooms are needed to ensure patients can complete their surgeries as early as possible during the week so they can begin rehab before the weekend or cans transfer to other post-acute environments. The proposed ten operating rooms are projected to be utilized at more than 95% the first three days of each week. The inpatient beds dedicated to the Joint Replacement Center are projected to be at 81.3% occupancy in year one and 92.9% in year four.

  The applicant provides the historical and projected Med/Surg bed capacity for all Med/Surg beds on page 28R of Supplemental 1. The overall projected bed occupancy of the 258 designated Med/Surg beds is 91.7% and 96.5% in years one and two of the project, respectively.

- The applicant states the renovation and updating the ED and its equipment is needed to achieve more efficient workflows, lessen patient transport to other areas of the hospital for diagnostic testing like CT scanning, provide more patient privacy and family counseling space, provide better rooms for psychiatric emergency patients, and to improve ambulance access. The applicant projects in CY 2014, the ED will serve 36,128 patients (1,290 per treatment station). In year two of this project, the updated ED is projected to serve 41,823 patients (1,743 per treatment station). The proposed 24 stations are consistent with room complements recommended by the American College of Emergency Physicians, and also comply with HCA's national planning standards for treatment room utilization.

The following chart was provided by the applicant and portrays the changes in bed assignments after the completion of the project.

Bed Type	Current Bed Assignment	Proposed Bed Assignment
Med/Surg	281	310
Obstetrical/Gyn	75	75
Adult Critical Care	88	88
Neonatal Intensive Care	60	60
Pediatric	21	21
Psychiatric	132	132
Rehabilitation	0	0
Total	**657**	**686**

TENNCARE/MEDICARE ACCESS:
The applicant will participate in the TennCare and Medicare programs. Centennial Medical Center contracts with AmeriGroup, United Healthcare, and TennCare Select MCO's.

Medicare revenue for the emergency department for year one is projected to one $38,002,090 or 22% of total gross revenues and TennCare revenues are projected to be $57,003, or 33% of total gross revenues.

The Joint Replacement Program Medicare revenue for year one is projected to be $165,713,157 or 57% of total gross revenues and TennCare revenue is projected to be $20,350,739 or 7% of total gross revenues.

ECONOMIC FACTORS/FINANCIAL FEASIBILITY:
The Department of Health, Division of Policy, Planning, and Assessment has reviewed the Project Costs Chart, the Historical Data Chart, and the Projected Data Chart to determine they are mathematically accurate and the projections are based on the applicant's anticipated level of utilization. The location of these charts may be found in the following specific locations in the Certificate of Need Application or the Supplemental material:

Project Costs Chart: The Project Costs Chart is located in the application in Supplemental 1. The total project cost is $92,192,007.

Historical Data Chart: The Historical Data Chart is located in the application. The applicant reported occupancy of 23,187, 25,830, and 28,064 days in 2011, 2012, and 2013, respectively. The applicant reported net operating revenues of $38,829,553, $38,775,724, and $46,665,365, respectively.

Projected Data Chart: The Projected Data Chart for the Joint Replacement Center of Excellence including the operating suites and 29 beds is located in Supplemental 1. The applicant projects 2,869 and 2,999 discharges in years one and two, respectively. The total net operating revenue in year one is projected to be $1,388,648 and $928,324 in year two of the project.

The Projected Data Chart for the Emergency Department projects 40,711 and 42,746 ED patients presenting in years one and two of the project with net operating income of $8,213,825 and $9,127,475 each year, respectively.

Average Charges Deductions, Net Charges and Income For Joint Replacement Center

	CY2016	**CY2017**
Average Gross Charge Per Day	$33,872	$36,480
Average Gross Charge Per Discharge	$101,333	$109,440
Average Deduction from Operating Revenue Per Day	$26,695	$29,394
Average Deduction from Operating Revenue Per Admission	$80,077	$88,183
Average Net Charge (Net Operating Revenue) Per Day	$7,086	$7,085
Average Net Charge (Net Operating Revenue) Per Admission	$21,256	$21,256
Average Net Operating Income After Expenses, Per Day	$161	$103
Average Net Operating Income After Expenses, Per Admission	$484	$310

Average Charges Deductions, Net Charges and Income For ED Room

	CY2016	**CY2017**
ED Visits, All Levels of Acuity	40711	42,746
Average Gross Charge Per Visit	$4,243	$4,582
Average Deduction per Visit	$3,540	$3,860
Average Net Charge	$703	$723

Average Net Operating Income	$202	$214

No alternatives were found by the applicant for this project.

CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTHCARE:
The applicant provides a listing of all contractual agreements in Supplemental 1.

The applicant believes the project will have only a positive impact on the community as it will give patients and emergency services personnel a significantly improved, more specialized and efficient physical environment for emergency care. It will also provide an expanding orthopedic medical staff and hospital staff with an optimal, complete, and self-contained continuum of care for the joint replacement patients and families.

The states the impact on current provides will be of short duration as the other facility to develop their own orthopedic and sports management program. The national demand for joint replacements for the aging population should provide sufficient demand for both the region's providers to implement and efficiently utilize integrated inpatient Centers of Excellence.

The applicant provides a list of their current and projected staffing on page 84 of the application.

The applicant has approximately 78 contractual relationships with health professions training programs and provides a list of these on page 86 0f the application.

Centennial Medical Center is licensed by the Tennessee Department of Health, Board for Licensing Healthcare Facilities and accredited by The Joint Commission. A copy of the most recent licensure inspection and plan of correction are provided in Attachment C, Orderly Development 7-(C).

SPECIFIC CRITERIA FOR CERTIFICATE OF NEED

The applicant responded to all relevant specific criteria for Certificate of Need as set forth in the document *Tennessee's State Health Plan.*

ACUTE CARE BED NEED SERVICES

1. The following methodology should be used and the need for hospital beds should be projected four years into the future from the current year:

   Using the latest utilization and patient origin data from the Joint Annual Report of Hospitals and the most current population projection series from the Department of Health, perform the following:

   Step 1

   Determine the current Average Daily Census (ADC) in each county.

   $$ADC = \frac{\text{Patient Days}}{365 \text{ (366 in leap year)}}$$

   Step 2

To determine the service area population (SAP) in both the current and projected year:

a. Begin with a list of all the hospital discharges in the state, separated by county, and showing the discharges both by the county where the patient actually lives (resident discharges), and the county in which the patient received medical treatment.

b. For the county in which the hospital is (or would be) located (service county), determine which other counties have patients who are treated in your county (resident counties). Treat all of the discharges from another state as if that whole state were a single resident county. The total discharges of residents from another state should be calculated from state population estimates and the latest National Center for Health Statistics southeastern discharge rates.

c. For each resident county, determine what percent of their total resident discharges are discharged from a hospital in your service county (if less than one percent, disregard).

d. For each resident county, apply the percentage determined above to the county's population (both projected and current). Add together the resulting numbers for all the resident counties and add that sum to the projected and current population of your service county. This will give you the service area population (SAP).

Step 3

Determine projected Average Daily Census as:

$$\text{Projected ADC} = \text{Current ADC} \times \frac{\text{Projected SAP}}{\text{Current SAP}}$$

Step 4

Calculate Projected Bed Need for each county as:

$$\text{Projected Need} = \text{Projected ADC} + 2.33 \times \sqrt{\text{Projected ADC}}$$

However, if projected occupancy:

$$\text{Projected Occupancy:} \quad \frac{\text{Projected ADC}}{\text{Projected Need}} \times 100$$

is greater than 80 percent, then calculate projected need:

$$\text{Projected Need} = \frac{\text{Projected ADC}}{.8}$$

There is a surplus in the applicant's designated service area of 1,455 acute care beds. In addition, no hospital in the applicant's service area has 80% occupancy.

2. New hospital beds can be approved in excess of the "need standard for a county" if the following criteria are met:

a) All existing hospitals in the projected service area have an occupancy level greater than or equal to 80 percent for the most recent Joint Annual Report. Occupancy should be based on the number of licensed beds that are staffed for two consecutive years.

No hospital in the applicant's service area has 80% occupancy.

b) All outstanding CON projects for new acute care beds in the proposed service area are licensed.

Vanderbilt Medical Center and Summit Medical Center have bed additions that are not yet implemented.

c) The Health Facilities Commission may give special consideration to acute care bed proposals for specialty health service units in tertiary care regional referral hospitals.

The applicant believes an exception is merited for the following reasons: TriStar Centennial Medical Center is a tertiary care, regional referral hospital, draws patients from 92 counties and 9 states, and offers highly advanced care programs in multiple specialties. The proposed 7th floor 29-bed unit is a specialized nursing unit for a joint replacement program. The unit varies from other medical/surgical units in terms of 1) its restricted patient population; 2) oversized rooms; 3) patients are separated from infectious patients; and 4) its physical and operational integration with surgery, recovery, and rehab stages of care.

CONSTRUCTION, RENOVATION, EXPANSION, AND REPLACEMENT OF HEALTH CARE INSTITUTIONS

1. Any project that includes the addition of beds, services, or medical equipment will be reviewed under the standards for those specific activities.

The applicant addressed this in the preceding criteria.

2. For relocation or replacement of an existing licensed health care institution:

a. The applicant should provide plans which include costs for both renovation and relocation, demonstrating the strengths and weaknesses of each alternative.

b. The applicant should demonstrate that there is an acceptable existing or projected future demand for the proposed project.

This criterion is not applicable.

3. For renovation or expansions of an existing licensed health care institution:

a. The applicant should demonstrate that there is an acceptable existing demand for the proposed project.

The applicant provided detailed information regarding the present and future demand for both the ED and surgical area improvement in Section B. II. C.

The project will allow for a more functional work flow in the ED with more specialized treatment rooms, improved accessibility for ambulances, privacy for family consultations, treatment rooms with more privacy, and other improvements.

The immenent arrival of a known joint replacement group and the creation of joint replacement Center of Excellence necessitates block scheduling of two surgical for surgical teams and immediate access to post-surgical rehab and care in a dedicated nursing unit with specialized staff and facilities.

b. The applicant should demonstrate that the existing physical plant's condition warrants major renovation or expansion.

This is not a renovation project to remedy an aging facility. This project is to provide needed new surgical environments for joint replacement patients.